PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

FOR

KENTUCKY PUBLIC PENSIONS AUTHORITY
MEDICAL ONLY PLAN

EFFECTIVE: JANUARY 1, 2025

Claims Administrator
Personify Health Solutions, LLC
P.O. Box 1590
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ARTICLE I -
INTRODUCTION

This is a self-insured and self-administered health benefit plan. The cost of this Plan is paid with contributions shared by the Kentucky Public Pensions Authority (KPPA) and the Covered Person. Benefits under this Plan are provided from the general assets of the Kentucky Public Pensions Authority (KPPA) through the Kentucky Retirement Systems insurance trust fund and are used to fund payment of covered claims under this Plan plus administrative expenses. Please contact Kentucky Public Pensions Authority (KPPA) for the method of calculating contributions and the funding mechanism used for the accumulation of assets through which benefits are provided under this Plan.

Kentucky Public Pensions Authority
1260 Louisville Road
Frankfort, KY 40601

Each Covered Person of the Kentucky Public Pensions Authority (KPPA) who participates in this Plan receives a Summary Plan Description, which is this booklet. This booklet will be provided to Covered Persons by the Kentucky Public Pensions Authority (KPPA). It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided and other Plan information.

This Plan's benefits and/or contributions may be modified or amended from time to time or may be terminated at any time by the Plan Sponsor. Significant changes to this Plan, including termination, will be communicated to Covered Persons as required by applicable law.

Upon termination of this Plan, the rights of the Covered Persons to benefits are limited to claims Incurred and payable by this Plan up to the date of termination. Plan assets, if any, will be allocated and disposed of for the exclusive benefit of the participating Covered Persons, except that any taxes and administration expenses may be made from this Plan's assets.

This Plan does not constitute a contract between the Kentucky Public Pensions Authority (KPPA) and any Covered Person and will not be considered as an inducement or condition of the employment of any Covered Person. Nothing in this Plan will give any Covered Person the right to be retained in the service of the Kentucky Public Pensions Authority (KPPA), or for the Kentucky Public Pensions Authority (KPPA) to discharge any Covered Person at any time.

This Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

Certain federal laws apply to most group health programs. The following is an overview of the laws and their impact. Should there be any conflict between the law and Plan provisions, the law will prevail.

Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Health Insurance Portability and Accountability Act (HIPAA) was enacted, among other things, to improve portability and continuity of health care coverage. HIPAA also requires that Covered Persons and beneficiaries receive a summary of any change that is a "Material Reduction in Covered Services or benefits under a group health plan" within sixty (60) days after the adoption of the modification or change, unless the Plan Sponsor provides summaries of modifications or changes at regular intervals of ninety (90) days or less.

Pregnancy Discrimination Act of 1978 ("PDA"). Most Employers must provide coverage for Pregnancy expenses in the same manner as coverage is provided for any other Illness. This requirement applies to Pregnancy expenses of a Retiree or a covered Dependent spouse of a Retiree.

Omnibus Budget Reconciliation Act of 1993 ("OBRA"). OBRA 1993 requires that an eligible Dependent Child of a Retiree will include a Child who is adopted by the Retiree or placed with them for adoption prior to age eighteen (18) and a Child for whom the Retiree or covered Dependent spouse is required to provide coverage due to a Medical

Child Support Order (MCSO) which is determined by the Plan Sponsor to be a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and having the force and effect of law under state law. Covered Persons may obtain a copy of the QMCSO procedures from the Plan Sponsor or Plan Administrator without charge.

Newborns' and Mothers' Health Protection Act of 1996 ("NMHPA"). The Newborns' and Mothers' Health Protection Act of 1996 establishes restrictions on the extent to which group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours). All applicable benefit provisions still apply, including Copayments and/or Coinsurance.

The Women's Health and Cancer Rights Act of 1998 ("WHCRA"). The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998. For health plans that cover a Mastectomy or Lumpectomy, if a Retiree or Dependent receives benefits under the Plan in connection with a Mastectomy or Lumpectomy and they elect breast reconstruction (in a manner determined in consultation with the attending Physician and the patient), coverage will be provided for:

- Reconstruction of the breast on which the Mastectomy or Lumpectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and/or
- Prostheses and treatment of physical complications at all stages of the Mastectomy and Lumpectomy, including lymphedemas.

Covered Expenses will be subject to the same annual Deductible, Copayment or Coinsurance provisions that currently apply to Mastectomy and Lumpectomy coverage and will be provided in consultation with the attending Physician.

Genetic Information Nondiscrimination Act of 2008 ("GINA"). GINA prohibits the Plan from:

1. Adjusting premiums or contribution amounts for the group as a whole on the basis of Genetic Information.
2. Requesting or requiring an individual or a family member to undergo a genetic test. However, subject to certain conditions, the Plan may request that an individual voluntarily undergo a genetic test as part of a research study as long as the results are not used for underwriting purposes.
3. Requesting, requiring or purchasing Genetic Information for underwriting purposes (which includes eligibility rules or determinations, computation of premium or contribution amounts and other activities related to the creation, renewal or replacement of coverage). The Plan is also prohibited from requesting, requiring or purchasing Genetic Information with respect to any individual prior to such individual's enrollment under the Plan or coverage. However, if the Plan obtains Genetic Information incidental to the collection of other information prior to enrollment, it will not be in violation of GINA as long as it is not used for underwriting purposes. GINA allows the group health Plan to obtain and use the results of genetic tests for purposes of making payment determinations.

What is "Genetic Information" under GINA? Under GINA, the term "Genetic Information" includes:

1. Information about an individual or their family member's genetic tests (defined as analyses of the individual's DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations or chromosomal changes);
2. The manifestation of a Disease or disorder in the family members of the individual. Family members are broadly defined under GINA to include individuals who are Dependents, as well as any other first, second, third or fourth degree relative. Further, Genetic Information includes that information of any fetus or embryo carried by a pregnant woman; and

3. Information obtained through genetic services (that is genetic tests, genetic counseling or genetic education) or participation in clinical research that includes genetic services.

Genetic Information does not include the sex or age of an individual.

Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). The Mental Health Parity and Addiction Equity Act requires that, if a group health plan provides coverage for mental health conditions or for substance use disorders, benefits for such conditions must be provided in the same manner as benefits for any Illness. Also, the Plan may not have separate cost-sharing arrangements that apply only to mental health or substance use disorder benefits.

Medicaid and The Children's Health Insurance Program ("CHIP") Offer Free or Low-Cost Health Coverage to Children and Families. If a Covered Person is eligible for health coverage from their Employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for Employer-sponsored health coverage but need assistance in paying their health premiums. If the Retiree or eligible Dependents aren't eligible for Medicaid or CHIP, they won't be eligible for these premium assistance programs, but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. If the Retiree or eligible Dependents are already enrolled in Medicaid or CHIP, they can contact the State Medicaid or CHIP office to find out if premium assistance is available. If the Retiree or eligible Dependents are NOT currently enrolled in Medicaid or CHIP, and they might be eligible for either of these programs, the State Medicaid or CHIP office can be contacted, or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply.

Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA"). Retirees and their Dependents who are otherwise eligible for coverage under the Plan but who are not enrolled can enroll in the Plan provided that they request enrollment in writing within sixty (60) days from the date of the following loss of coverage or gain in eligibility:

- The eligible person ceases to be eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage; or
- The eligible person becomes newly eligible for a premium subsidy under Medicaid or CHIP.

If eligible, the Dependent (and if not otherwise enrolled, the Retiree) may be enrolled under this Plan.

This Dependent special enrollment period is a period of sixty (60) days and begins on the date of the loss of coverage under the Medicaid or CHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid or CHIP. To be eligible for this Special Enrollment, the Retiree must request enrollment in writing during this sixty (60) day period. *The effective date of coverage will begin the first day of the first calendar month following the date of loss of coverage or gain in eligibility.*

If a State in which the Retiree lives offers any type of subsidy, this Plan shall also comply with any other State laws as set forth in statutes enacted by State legislature and amended from time to time to the extent that the State law is applicable to the Plan, the Employer, and its Retirees. **For more information regarding special enrollment rights, contact the Plan Administrator.**

No Surprises Act ("NSA"). The No Surprises Act, part of Title I of the Consolidated Appropriations Act of 2021, prohibits Physicians, Providers, health care facilities and air ambulance companies from balance billing Covered Persons or otherwise holding Covered Persons liable for any more than the applicable cost sharing amounts they would have owed for network care. Specifically, these balance billing protections apply when a Covered Person receives Emergency Services from a Non-Network Provider or facility, when a Covered Person receives non-Emergency Services from a Non-Network Provider at a Network Facility, and when a Covered Person receives non-network air ambulance services.

However, these protections against balance billing do not apply if the Covered Person consents to treatment by a Non-Network Provider (this consent exception generally does not apply in emergency situations).

In addition, this Plan generally will cover Emergency Services; cover Emergency Services by Non-Network Providers; base cost sharing amounts on network benefits; and count any cost sharing amounts for Emergency Services or non-network services toward a Covered Person's out-of-pocket limit.

If a Covered Person believes they have received a balance bill that is protected under the No Surprises Act, please contact Personify Health Solutions, LLC for additional information.

Please visit www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for additional information regarding the No Surprises Act.

In the event of an inconsistency between this Summary Plan Description/Plan Document and the law relative to the No Surprises Act, the law prevails only to the extent required to satisfy compliance.

The Civilian Reservist Emergency Workforce Act of 2021 ("CREW"). Beginning September 29, 2022, the CREW Act provides Eligible Retirees, who are called to service by the Federal Emergency Management Agency ("FEMA") to respond to and perform services responding to natural disasters and emergencies, rights under the Uniformed Employment and Reemployment Rights Act ("USERRA"). *See USERRA section for additional information regarding benefits and coverage during such leave.*

Grandfather Clause. This group health plan believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply, and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at:

Kentucky Public Pensions Authority
1260 Louisville Road
Frankfort, KY 40601
(502) 696-8800

The Covered Person may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

ARTICLE II -
DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Accident means a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

Accidental Injury means an Injury sustained as the result of an Accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment for a claim that is based on any: (a) determination of an individual's eligibility to participate in a Plan or health insurance coverage; (b) determination that a claimed benefit is not a Covered Service; (c) imposition of a source-of-injury Exclusion, or other limitation on otherwise Covered Services; (d) determination that a claimed benefit is Experimental and/or Investigational, or not Medically Necessary or appropriate; (e) invalid charges; or (f) improper balance, of (g) as otherwise defined in the Plan.

Affordable Care Act (ACA) means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

Allowable Expense(s) means any Medically Necessary item of expense, at least a portion of which is covered under this Plan. When some other plan pays first in accordance with the Coordination of Benefits, this Plan's Allowable Expenses shall in no event exceed the other plan's Allowable Expenses. When some other plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be the benefit. Benefits payable under any other plan include the benefits that would have been payable had claim been duly made therefore, whether or not it is actually made.

Alternate Recipient means any Child of a Covered Person who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Covered Person's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements, an Alternate Recipient shall have the same status as a Covered Person.

Ambulatory Surgical Center means any public or private State licensed and approved (whenever required by law) establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous Physician services and registered professional nursing service whenever a Covered Person is in the facility, and which does not provide service or other accommodations for Covered Persons to stay overnight.

Approved Clinical Trial means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or a non-governmental entity identified by NIH guidelines) or is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

The 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 Physician has concluded that participation is appropriate, or the Covered Person provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the Plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include: (a) the investigational item, device or service itself; (b) 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 Covered Person; (c) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis; (d) and/or items and/or services to be paid for and or provided at no cost from a third party (including but not limited to a manufacturer.)

Authorized Representative means a person designated by the Covered Person to act on their behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be made in writing, signed and dated by the Covered Person, and include all information required in the Authorized Representative form.

Calendar Year means the twelve (12) month period beginning on January 1 and ending the following December 31.

Certified Independent Dispute Resolution (IDR) Entity means an entity responsible for conducting determinations under the No Surprises Act (NSA) that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

Child and/or Children means the Retiree's natural child, any stepchild, legally adopted child, or any other Child for whom the Retiree has been named Legal Guardian, or an "eligible foster child," which is defined as an individual placed with the Retiree by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction. For purposes of this definition, a legally adopted child shall include a Child placed in a Retiree's physical custody in anticipation of adoption. "Child" shall also mean a covered Retiree's Child who is an Alternate Recipient under a Qualified Medical Child Support Order, as required by the Federal Omnibus Budget Reconciliation Act of 1993.

Claimant means a Covered Person or an Authorized Representative of a Covered Person making a claim or for whom a claim is made.

Claims Administrator/Fiduciary is Personify Health Solutions, LLC.

Clean Claim means one that can be processed in accordance with the terms of this Plan without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this Plan, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this Plan, and only as permitted by this Plan, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity, or fees under review for Maximum Allowable Charge or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this Plan.

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

CMS means Centers for Medicare and Medicaid Services.

Coinsurance means a cost sharing feature of many plans. It requires a Covered Person to pay out-of-pocket a prescribed portion of the cost of Covered Expenses. The defined Coinsurance that a Covered Person must pay out-of-pocket is based upon their health plan design. Coinsurance is established as a predetermined percentage of the Maximum Allowable Charge for Covered Services.

Copayment or Copay means the specified dollar amount that a Covered Person must pay each time certain medical care is provided, as specified in the Medical Benefits Schedule.

Covered Expense(s)/Covered Service(s) are Provider charges for Covered Services. Covered Expenses are billed charges minus non-Covered Expenses and invalid charges. Covered Expenses also means a reasonable fee for an appropriate, Medically Necessary service, treatment or supply, meant to improve a condition or Covered Person's health, which is specified in this Plan as a Covered Expense. Covered Expenses will be determined based upon all other Plan provisions.

All treatment is subject to benefit payment maximums shown in the Medical Benefits Schedule and as determined elsewhere in this Plan.

Covered Person means a Retiree and their eligible Dependents, a COBRA Qualified Beneficiary, a COBRA Qualified Beneficiary's Dependent or other person meeting the eligibility requirements for coverage as specified in the Plan, and who is properly enrolled in the Plan.

Custodial Care means care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Deductible means an amount of money that is paid once a Calendar Year per Covered Person and Family Unit. Typically, there is one Deductible amount per Plan, and it must be paid before any money is paid by the Plan for any medical care.

Dentist means a properly trained person holding a D.D.S. or D.M.D. degree and practicing within the scope of a license to practice dentistry within their applicable geographic venue.

Dependent(s) means the covered Retiree's eligible family members as outlined in this Plan.

Diagnosis means the act or process of identifying or determining the nature and cause of an Illness or Injury through evaluation of Covered Person history, examination, and review of laboratory data.

Diagnostic Service means an examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the identification of a Disease or Injury. The Diagnostic Service must be ordered by a Physician or other professional Provider.

Disease means any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as a Retiree under any worker's compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as an Illness or Disease.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Services means a medical screening examination and associated services to treat a condition that requires immediate medical attention that would reasonably expect to result in (a) serious jeopardy to the health of an individual (or in the case of a pregnant person, the health of the unborn child); (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part. Emergency Services include pre-stabilization services that are provided after a patient is moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after a patient is stabilized as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which other Emergency Services are furnished. These services include those provided at an Independent Freestanding Emergency Department as well as a Hospital emergency department. A decision of what constitutes Emergency Services will not be defined solely on the basis of the Diagnosis but rather will be a determination that takes into account the reasonableness of each situation as defined by a prudent layperson.

Employer is Kentucky Public Pensions Authority and any entity under common control as elected by the Plan Administrator to participate in the Plan.

Errors mean any billing mistakes or improprieties including, but not limited to, up-coding, duplicate charges, charges for care, supplies, treatment, and/or medical care 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.

Excess Charge means a charge or portion thereof billed for care and/or treatment of an Illness or Injury that is not payable under the terms of the Plan because it exceeds the Maximum Allowable Charge or is determined by the Plan Administrator to be based on Invalid Charges or Errors as defined by this Plan Document. Also, charges for a service or supply furnished by a direct contract Provider in excess of the applicable negotiated rate.

Exclusion means conditions or services that this Plan does not cover.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

a. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

b. If the drug, device, medical treatment or procedure, or the Covered Person informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if Federal law requires such review or approval; or

c. *Except as provided under the Approved Clinical Trial benefit in the Medical Benefits within the Covered Expenses section*, if reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or Diagnosis; or

d. If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or Approved Clinical Trials are necessary to determine its

maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or Diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit means the covered Retiree and the family members who are covered as Dependents under the Plan.

FDA means the Food and Drug Administration.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide home health care services and supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Hospital means an Institution that meets all of the following requirements:

a. It provides medical and surgical facilities for the treatment and care of injured or sick persons on an Inpatient basis;
b. It is under the supervision of a staff of Physicians;
c. It provides twenty-four (24) hours a day nursing service by registered nurses (R.N.);
d. It is duly licensed as a Hospital, except that this requirement will not apply in the case of a state tax supported Institution;
e. It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training type Institution, or an Institution which is supported in whole or in part by a federal government fund;
f. It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA;
g. The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA; and
h. In addition to those facilities that meet all of the requirements above, the definition of "Hospital" for purposes of this document, unless otherwise specifically stated, shall also include any facility that solely provides medical care on an Outpatient basis whether affiliated with a Hospital as defined above or not ("independent facilities"), including but not limited to an Ambulatory Surgical Center.

Illness means a bodily disorder, Disease, physical Illness or Mental or Nervous Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Incurred means that a Covered Expense is Incurred on the date the service is rendered, or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Independent Freestanding Emergency Department means a health care Facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services. Independent Freestanding Emergency Departments do not include urgent care centers or clinics.

Injury means an Accidental Injury to the body caused by unexpected external means.

Inpatient means a Covered Person who receives medical care at a Hospital and is admitted as a registered overnight bed patient.

Institution means a facility created and/or maintained for the purpose of practicing medicine and providing organized health care and treatment to individuals, operating within the scope of its license, such as a Hospital, Ambulatory Surgical Center, psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Use Disorder treatment center, alternative birthing center, or any other such facility that the Plan approves.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lumpectomy means the surgical removal of a small tumor, which may be benign or cancerous.

Mastectomy means the surgical removal of all or part of a breast.

Maximum Allowable Charge means the benefit payable for a specific coverage item or benefit under the Plan. The Plan Administrator has the discretionary authority to decide if a charge is covered under this Plan and has the ultimate discretionary authority to determine the Maximum Allowable Charge. The Maximum Allowable Charge may be any one of the following, as determined by the Plan Administrator:

1. The charge made by the Provider that furnished the care, service, or supply;
2. The negotiated rate established by a negotiated arrangement; or
3. An amount determined by the Plan Administrator, using normative data and submitted information such as, but not limited to, any one or more of the following, in the Plan Administrator's discretion:
    a. Medicare reimbursement rates (presently utilized by the Centers for Medicare and Medicaid Services (CMS);
    b. Prices established by CMS utilizing standard Medicare payment methods and/or based upon supplemental Medicare pricing data for items Medicare doesn't cover based on data from CMS;
    c. Prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained providers of care;
    d. Prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained providers of care in traditional settings;
    e. Medicare cost data as reflected in the applicable individual provider's cost report(s);
    f. The fee(s) which the Provider most frequently charges the majority of patients for the service or supply;
    g. Amounts the Provider specifically agrees to accept as payment in full either through direct negotiation or through a preferred provider organization (PPO) network;
    h. Average wholesale price (AWP) and/or manufacturer's retail pricing (MRP);
    i. Medicare cost-to-charge ratios or other information regarding the actual cost to provide the service or supply;
    j. The allowable charge otherwise specified within the terms of this Plan;
    k. The prevailing range of fees charged in the same "area" (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) by Providers of similar training and experience for the service or supply;
    l. With respect to non-network Emergency Services, the Plan allowance is the greater of:

- The negotiated amount for Network Providers (the median amount if more than one amount to Network Providers).
- One hundred percent (100%) of the Plan's Maximum Allowable Charge payment formula (reduced for cost-sharing).
- The amount that Medicare Parts A or B would pay (reduced for cost-sharing); or

m. For claims subject to the No Surprises Act, if an initial payment under the Plan is challenged and no negotiation and/or settlement occurs resulting in a negotiated rate, the Maximum Allowable Charge will be the amount deemed payable by a certified independent dispute resolution entity as outlined in applicable law.

The Plan Administrator may take any or all of such factors into account but has no obligation to consider any particular factor. The Plan Administrator may also account for unusual circumstances or complications requiring additional or a lesser amount of time, skill and experience in connection with a particular service or supply, industry standards and practices as they relate to similar scenarios, and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

In all instances, the Maximum Allowable Charge will be limited to an amount which, in the Plan 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 and/or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

The determination that fees for services are includable in the Maximum Allowable Charge will be made by the Plan Administrator, taking into consideration, but not limited to, the findings and assessments of the following entities: (a) The national medical associations, societies, and organizations; and (b) The Food and Drug Administration (FDA). To be includable in the Maximum Allowable Charge, services and fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The Plan Administrator has the discretionary authority to decide if a charge is covered under this Plan and has the ultimate discretionary authority to determine the Maximum Allowable Charge. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medical Child Support Order means any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that meets one of the following requirements:

a. Provides for child support with respect to a Covered Person's Child or directs the Covered Person to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law).
b. Is made pursuant to a law relating to medical child support described in §1908 of the Social Security Act (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

Medically Necessary or Medical Necessity refers to medical care ordered by a Physician exercising prudent clinical judgment provided to a Covered Person for the purposes of evaluation, Diagnosis or treatment of that Covered Person's Illness or Injury. For such medical care to be considered Medically Necessary, it must be clinically appropriate in terms of type, frequency, extent, site and duration for the Diagnosis or treatment of the Covered Person's Illness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Covered Person's medical symptoms and conditions, cannot be provided in a less intensive medical setting. For such medical care to be considered Medically Necessary it must be no more costly than alternative interventions and are at least as likely to produce equivalent therapeutic or diagnostic results as to the Diagnosis or treatment of the Covered Person's Illness or Injury without adversely affecting the Covered Person's medical condition. In order for a service to be considered Medically Necessary: (a) it must not be maintenance therapy or maintenance treatment; (b) its purpose must be to restore health; (c) it must not be primarily custodial in nature.

For Hospital stays, Medically Necessary means that acute care as an Inpatient is necessary due to the kind of medical care the Covered Person is receiving, or the severity of the Covered Person'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 medical care is recommended, ordered, prescribed, approved or furnished by a Physician or Dentist 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 of these criteria must be met. The determination of whether medical care, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors or medical advisors to the Claims Administrator. The Plan Administrator has the ultimate discretionary authority to determine whether care or treatment is or was Medically Necessary.

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.

Off-label drug use is considered Medically Necessary when all of the following conditions are met:

a. The drug is approved by the Food and Drug Administration (FDA).
b. The prescribed drug use is supported by one of the following standard reference sources:
    i. Micromedex® DRUGDEX®.
    ii. The American Hospital Formulary Service Drug Information.
    iii. Medicare approved compendia.
    iv. Scientific evidence is supported in well-designed Approved Clinical Trials published in peer-reviewed medical journals, which demonstrate that the drug is safe and effective for the specific condition.
c. The drug is otherwise Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

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

Mental or Nervous Disorder means any Disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

National Medical Support Notice (NMSN) means a notice that contains all of the following information:

a. The name of an issuing State child support enforcement agency.
b. The name and mailing address (if any) of the Retiree who is a Covered Person under the Plan or eligible for enrollment.
c. The name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Covered Person) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s).
d. Identity of an underlying child support order.

Network Provider or Network Facility means a healthcare institution or healthcare provider who has by contract agreed to provide services at discounted reimbursement rates. A single direct contract or case agreement between a health care Facility and a Plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

Non-Network Provider or Non-Network Facility means a healthcare institution or healthcare provider who does not have a contractual relationship with the Plan or issuer, respectively, regarding reimbursement of items or services they provide.

Outpatient means a Covered Person who receives medical care at a Hospital but is not admitted as a registered overnight bed patient; this must be for a period of less than twenty-four (24) hours.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where they practice.

Physician means a person permitted to perform services provided by this Plan who is legally entitled to perform certain medical services according to applicable and current licensure, certification or registration ("License" or "Licensed" or "Licensure") in the state or jurisdiction where the services are rendered. The person must be acting within the scope of their Licensure and must hold one of the following Licenses, degrees and/or titles: Medical Doctor or Surgeon (M.D.); Doctor of Osteopathy (D.O.); Doctor of Optometry (O.D.); Doctor of Podiatric Medicine (D.P.M.); Doctor of Dental Surgery (D.D.S.); Doctor of Dental Medicine (D.M.D.); or Doctor of Chiropractic (D.C.).

Plan means Kentucky Public Pensions Authority Group Health Plan which is a benefits plan for covered Retirees (and their eligible Dependents) of Kentucky Public Pensions Authority.

Plan Administrator means Kentucky Public Pensions Authority.

Plan Manager is Humana Insurance Company. Humana has contracted with Personify Health to provide certain delegated administrative duties, including the processing of claims. The Claims Fiduciary is Personify Health Solutions, LLC.

Plan Sponsor means Kentucky Public Pensions Authority on behalf of the Kentucky Retirement Systems and the County Employee Retirement System.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under Federal law, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

Provider means a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or facility defined or listed herein, or approved by the Plan Administrator.

Residential Treatment Center and Wilderness Camps Programs means a facility and/or program that provides treatment twenty-four (24) hours a day and can usually serve more than twelve (12) people at a time. Treatment may include individual, group and family therapy, behavior therapy, special education, recreation therapy, or medical services. Residential treatment is usually more long-term than Inpatient Hospitalization. Residential treatment is for (1) severe and persistent Mental or Nervous Disorder that results in the person being unable to maintain independent functioning without support and continued treatment for an indefinite period of time; or (2) Substance Use Disorder in which the patient is at a high risk for relapse.

Retiree means a Covered Person who is a former employee of an employer participating in the retirement systems administered by Plan Administrator, and who meets the requirements for retirement as determined by Kentucky Public Pensions Authority (KPPA).

Skilled Nursing Facility is a facility that fully meets all of these tests:

a. It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse

(L.P.N.) under the direction of a registered nurse. Services to help restore Covered Persons to self-care in essential daily living activities must be provided.

b. Its services are provided for compensation and under the full-time supervision of a Physician.
c. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
d. It maintains a complete medical record on each Covered Person.
e. It has an effective Utilization Review plan.
f. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, custodial or educational care or care of Mental or Nervous Disorders.
g. It is approved and licensed by Medicare.

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Substance Use Disorder means any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The DSM-V definition is applied as follows:

a. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve (12) month period:
    i. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of Children or household);
    ii. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
    iii. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); or
    iv. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).
b. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Total Disability (Totally Disabled) means, in the case of a Dependent, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Retiree for support and maintenance and unmarried. To prove Total Disability, the covered Retiree must prove that they have claimed the Dependent on their tax returns.

Waiting Period means the time between the first day of employment as an eligible Retiree and the first day of coverage under the Plan.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ARTICLE III -
OVERVIEW OF BENEFITS

MEDICAL BENEFITS

All benefits described in the Medical Benefits Schedule are subject to the Exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; charges are limited to the Maximum Allowable Charge as defined; and services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are outlined under Defined Terms of this Plan.

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all Covered Expenses and/or Exclusions with specificity. Please contact the Claims Administrator regarding questions about specific supplies, treatments, or procedures.

This Plan pays Covered Expenses pursuant to the Maximum Allowable Charge, which is defined in this Plan. **Covered Persons are responsible for any amounts determined to be in excess of the Maximum Allowable Charge.**

CHOICE OF PROVIDERS

The Plan is not intended to disturb the Physician-patient relationship. Each Covered Person has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other health care Providers are not agents or delegates of the Plan Sponsor, Plan Administrator, Employer or Claims Administrator. The delivery of medical and other health care services on behalf of any Covered Person remains the sole prerogative and responsibility of the attending Physician or other health care Provider. The Covered Person, together with their Physician, is 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.

ARTICLE IV -
MEDICAL BENEFITS SCHEDULES

MEDICAL ONLY PLAN

This schedule provides an overview of the Plan benefits. For a more detailed description of Plan benefits, refer to the Medical Benefits section. **Plan benefits for Covered Expenses are applicable after Medicare Parts A & B benefits have been applied less the Medicare deductible. The Plan pays for services that are Medicare covered.**

Claims must be received by the Claims Administrator within ***456 days*** from the date charges for the services were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred. Claims received later than that date may be denied.	
LIFETIME MAXIMUM BENEFIT	**UNLIMITED**
DEDUCTIBLE, PER CALENDAR YEAR	
Per Covered Person	$500
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR	
Per Covered Person	$500
The following expenses may not count toward the maximum out-of-pocket amount and will not be paid at 100% even when the maximum out-of-pocket has been met. • Non-compliance penalties. **Amounts outlined in this schedule are the Covered Person's responsibility amounts.**	
Covered Expenses are limited to the Maximum Allowable Charge as defined; Medical Necessity and subject to all other provisions, conditions, limitations and Exclusions of this Plan.	
DESCRIPTION	**BENEFIT**
Acupuncture	Not covered.
Ambulance (Air & Ground)	No cost to Covered Person after Deductible is met.
Ambulatory Surgical or Outpatient Surgical Facility	No cost to Covered Person after Deductible is met.
Applied Behavioral Analysis (ABA) Therapy	Not covered.
Cardiac Rehabilitation	No cost to Covered Person after Deductible is met.
Cellular Therapy	Pays the same as any other Illness.
Chemotherapy & Radiation Therapy	No cost to Covered Person after Deductible is met.
Chiropractic Care Provider must send letter of Medical Necessity and all applicable notes. Limitations vary according to Medicare guidelines.	No cost to Covered Person after Deductible is met.
Diabetes Self-Management Training	No cost to Covered Person, Deductible waived.
Diagnostic Testing	
Advanced Imaging – Any Location *Includes MRI, CAT, PET, nuclear, stress tests, etc.*	No cost to Covered Person after Deductible is met.
Lab & X-ray – Any Location	No cost to Covered Person after Deductible is met.
Durable Medical Equipment (DME)	No cost to Covered Person after Deductible is met.
Emergency Room Services	No cost to Covered Person after Deductible is met.
Home Health Care	No cost to Covered Person after Deductible is met.

DESCRIPTION	BENEFIT
Hospice Care	No cost to Covered Person after Deductible is met.
Hospital Services	
Inpatient Services – Days 1 through 150 *Limited to 365 days total per lifetime. The 60 day Medicare lifetime reserve days must be used before the Plan will pay. The Plan pays the Covered Person's Medicare Part A Deductible for the first 60 days and their Medicare Part A Coinsurance for 61-150 days.*	No cost to Covered Person, Deductible waived.
Inpatient Services – Care Beyond 150 Days *Limited to 365 days total per lifetime.*	20% Coinsurance, Deductible waived.
Outpatient Services	No cost to Covered Person after Deductible is met.
Impacted Wisdom Teeth	Pays the same as any other Illness.
Maternity Care	
Office Based Services	Pays the same as any other Illness.
Newborn Inpatient Routine Care	No cost to Covered Person after Deductible is met.
Mental or Nervous Disorders and Substance Use Disorder Treatment	
Inpatient Services – Days 1 through 150 *Limited to 365 days total per lifetime. The 60 day Medicare lifetime reserve days must be used before the Plan will pay. The Plan pays the Covered Person's Medicare Part A Deductible for the first 60 days and their Medicare Part A Coinsurance for 61-150 days.*	No cost to Covered Person, Deductible waived.
Inpatient Services – Care Beyond 150 Days *Limited to 365 days total per lifetime.*	20% Coinsurance Deductible waived.
Outpatient Services *Does include partial hospitalization.*	Pays the same as any other Illness.
Office Based Services	No cost to Covered Person after Deductible is met.
Occupational Therapy Provider must send letter of Medical Necessity and all applicable notes.	No cost to Covered Person after Deductible is met.
Physical Therapy Provider must send letter of Medical Necessity and all applicable notes.	No cost to Covered Person after Deductible is met.
Physician Services	
Primary Care Office Visit – In-Person & Virtual	No cost to Covered Person after Deductible is met.
Specialist Office Visit – In-Person & Virtual	No cost to Covered Person after Deductible is met.
Office Based Surgery	No cost to Covered Person after Deductible is met.
Telehealth (Teladoc)	No cost to Covered Person, Deductible waived.
Professional Services	No cost to Covered Person after Deductible is met.
Preventive Care	No cost to Covered Person after Deductible is met.
Private Duty Nursing Services Limited to $2,500 per Calendar Year.	20% Coinsurance after Deductible is met.
Prosthetics and Orthotics	No cost to Covered Person after Deductible is met.
Skilled Nursing Facility and Extended Care	No cost to Covered Person after Deductible is met.
Sleep Studies	No cost to Covered Person after Deductible is met.
Speech Therapy Provider must send letter of Medical Necessity and all applicable notes.	No cost to Covered Person after Deductible is met.

DESCRIPTION	BENEFIT
Sterilization Services	No cost to Covered Person after Deductible is met.
Transplant Services	
Recipient Services – Facility & Professional	Refer to applicable service for benefits.
Donor Services – Facility & Professional *Includes evaluating the organ, removing the organ, from the donor, and transportation of the organ to the place where transplant is to be performed.*	Refer to applicable service for benefits.
Travel and Accommodations *Limited to $10,000 total per Calendar Year.*	No cost to Covered Person after Deductible is met.
Urgent Care	No cost to Covered Person after Deductible is met.

ARTICLE V -
ELIGIBILITY AND ENROLLMENT PROVISIONS

ELIGIBILITY

Eligible Retirees

- Retirees of Kentucky Public Pensions Authority.

Eligibility Requirements for Coverage. A Retiree is eligible for coverage under the Plan if they are the recipient of a monthly retirement allowance from Kentucky Public Pensions Authority either:

- Under its formal retirement program, and the Retiree is eligible for Medicare, or
- Due to a disability, and the Retiree is eligible for Medicare as a result of that disability.

A Retiree can also enroll their eligible Dependents in this Plan. They too must be Medicare eligible.

If the Retiree would like medical coverage under this Plan, they must apply for it within thirty (30) calendar days following the first of the month that their first retirement allowance is issued. If the Retiree does not apply for coverage within that time frame, they will have to wait for the annual open enrollment period or for a qualified status change. The Retiree can enroll for coverage or change their current Plan coverage during the annual open enrollment period. The Retiree also can enroll in the Plan if they become newly eligible during the year or if they experience a qualified status change.

When Coverage Begins. If the Retiree makes a coverage election during the annual open enrollment period, their coverage becomes effective on the next January 1. If the Retiree makes a new coverage election during the Calendar Year, their coverage becomes effective on the first day of the month following the month in which the retirement office receives their enrollment form. The effective date of the coverage can be no earlier than the Covered Person's Medicare eligibility date.

When Changes Can be Made. A Covered Person may change their Plan coverage during the year if they have a qualified status change. If the Covered Person wants to change their election as a result of a status change, their new election must be made within thirty (30) days from the date of the status change. Status changes include:

1. Marriage, divorce, legal separation or annulment.
2. Birth or adoption (or placement for adoption) of a Child.
3. Death of a covered spouse or Child.
4. Loss or gain eligibility for insurance coverage for the Covered Person. This does not include a voluntary termination of coverage. This does include non-payment of premiums.
5. Change in employment status including termination or commencement of employment, a commencement of or a return from an unpaid leave of absence, or a change in work schedule (including part-time to full-time or vice versa) for the Covered Person.
6. Change in health insurance eligibility due to a relocation of residence or workplace for the Covered Person. Applies to members returning home from out of the country or leaving jail.
7. A judgment, decree or order resulting from the Covered Person's marriage, divorce, legal separation, annulment or change in child custody requiring them to add or allowing them to drop coverage for their Dependents.
8. The Covered Person's entitlement to Medicare benefits. If the Covered Person did not enroll in Medicare Part B, at the time they became eligible, subsequent enrollment in Part B is not a qualifying event allowing them to enroll in the Plan outside of the annual open enrollment period.
9. A significant increase in cost, or reduction in benefits, of coverage under the Plan or the Retiree's spouse's plan.
10. A change in a spouse or Dependent Child's coverage under another plan that would permit a new election under that plan and applicable IRS regulations.

11. The Covered Person's prior coverage was COBRA continuation that has since been exhausted. The Covered Person has thirty (30) days from the date of the status change to revise their elections. Please keep in mind that the change the Covered Person requests must be consistent with their status change. For instance, if the Covered Person adopts a Child, they may enroll their new Dependent for medical coverage, but they cannot change medical plan options. Generally, the Covered Person's change in coverage will become effective on the first day of the month following the month in which the retirement office receives their enrollment form

Eligible Classes of Dependents. A Dependent must be eligible for Medicare to be enrolled in this Plan. A Dependent is any one of the following persons:

1. A covered **Retiree's legal spouse and Children** from birth until the limiting age of twenty-six (26) years. When the Child reaches the limiting age, coverage will end on the last day of the Child's birthday month.

   The term **"spouse"** means a person recognized as the covered Retiree's husband or wife by the laws of the state or country in which the marriage was formalized. "Married" means a legal union between two individuals and will not include a common law spouse. The Plan Administrator may require documentation proving a legal marital relationship.

   The term **"Children"** means natural children, adopted children, foster children, Children placed with a covered Retiree in anticipation of adoption, stepchildren and grandchildren.

   If a covered Retiree is the **Legal Guardian** of a Child or Children, these Children may be enrolled in this Plan as covered Dependents.

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

   Any Child of a Covered Person who is an Alternate Recipient under a **Qualified Medical Child Support Order (QMCSO)** shall be considered as having a right to Dependent coverage under this Plan. A Covered Person of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

   Please be advised, the definition of "Dependent" may not be the same definition as established by the Internal Revenue Code (IRC) for individuals that the covered Retiree is permitted to pay qualified medical expenses from a Health Savings Account (HSA), or individuals that can be enrolled as an eligible Dependent for tax free benefits. (i.e., non-IRC Section 152 Dependent). There may be tax implications for the Retiree if they enroll certain eligible Dependent(s). The Retiree should consult their tax advisor with any questions on the tax consequences of benefits for their eligible Dependent(s).

   The Plan Administrator may require documentation proving dependency, including birth certificates or initiation of legal proceedings severing parental rights.

2. A covered Dependent Child who reaches the **limiting age** and is **Totally Disabled**, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Retiree for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the Child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Retiree's home, but who are not eligible as defined; the legally separated or divorced former spouse of the Retiree; or any person who is covered under the Plan as an employee.

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

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

Effective Date of Dependent Coverage. Coverage will begin on the day that the eligibility requirements are met; the Retiree is covered under the Plan; and all enrollment requirements are met.

ENROLLMENT

TIMELY, LATE OR OPEN ENROLLMENT

1. **Timely Enrollment.** The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than thirty (30) days after the person becomes eligible for the coverage either initially or under a special enrollment period.

   If two Retirees (husband and wife) are covered under the Plan and the Retiree who is covering the Dependent Children terminates coverage, the Dependent coverage may be continued by the other covered Retiree.

2. **Late Enrollment.** An enrollment is "late" if it is not made on a "timely basis" or during a special enrollment period. Late enrollees and their Dependents who are not eligible to join the Plan during a special enrollment period may join only during open enrollment.

   If an individual loses eligibility for coverage as a result of terminating employment, a reduction of hours of employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a late enrollee.

3. **Open Enrollment.** Each year there is an annual open enrollment period designated by the Plan Administrator during which Covered Persons may change their benefit elections under the Plan, and Retirees and their Dependents, who are late enrollees, will be able to enroll in the Plan.

   Benefit choices for late enrollees made during the open enrollment period will become effective as of the start of the new plan year. Covered Persons will receive detailed information regarding open enrollment from the Plan Administrator.

   Benefit choices made during the open enrollment period will remain in effect until the next open enrollment period unless there is a special enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a spouse's employment.

   If a Retiree drops spousal coverage during open enrollment in anticipation of divorce, the covered Retiree should notify the Plan Administrator.

The Retiree will be required to enroll the newborn child on a timely basis, as defined in the section "Timely, Late or Open Enrollment" above, or there will be no payment from the Plan and the parents will be responsible for all costs.

SPECIAL ENROLLMENT RIGHTS

Federal law provides special enrollment provisions under some circumstances. If a Retiree is declining enrollment for themself or their Dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the Employer stops contributing towards the other coverage).

In addition, if a Retiree or their Dependents (including their spouse) is losing coverage due to a loss of a government sponsored subsidy (due to ineligibility for coverage or cost of coverage) there may be a right to enroll in this Plan.

However, a request for enrollment must be made within thirty (30) days after the coverage ends (or after the Employer stops contributing towards the other coverage).

In addition, in the case of a birth, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within thirty (30) days of the date of birth, adoption or placement for adoption or of the date of marriage.

The special enrollment rules are described in more detail below. To request special enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.

SPECIAL ENROLLMENT PERIODS

The enrollment date for anyone who enrolls under a special enrollment period is the first date of coverage. The events described below may create a right to enroll in the Plan under a special enrollment period.

1. **Losing other coverage may create a special enrollment right.** A Retiree or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

    a. The Retiree or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
    b. If required by the Plan Administrator, the Retiree stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
    c. The coverage of the Retiree or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because Employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date of loss.
    d. The Retiree or Dependent requests enrollment in this Plan not later than thirty (30) days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of Employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date of loss.

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

    a. The Retiree or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e., part-time, Retirees);
    b. The Retiree or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent Child

under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated;

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

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

e. Loss or gain of eligibility for insurance coverage for the Retiree or a covered Dependent. This does not include a voluntary termination of coverages. This includes non-payment of premiums;

f. Change in employment status including termination or commencement of employment, a commencement of or a return from an unpaid leave of absence or a change in schedule (including part-time to full-time or vice versa) for the Retiree or their Dependent;

g. Change in health insurance eligibility due to a relocation of residence or workplace for the Retiree or their Dependent. This applies to members returning home from out of country, or leaving jail; or

h. A judgment, decree or order resulting from the Covered Person's marriage, divorce, legal separation, annulment or change in child custody requiring them to add or allowing them to drop coverage for their Dependents.

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

2. Acquiring a newly eligible Dependent may create a special enrollment right if:

a. The Retiree is a Covered Person under this Plan, and

b. A person becomes a Dependent of the Retiree through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Retiree) may be enrolled under this Plan. In the case of the birth or adoption of a Child, the spouse of the covered Retiree may be enrolled as a Dependent of the covered Retiree if the spouse is otherwise eligible for coverage. If the Retiree is not enrolled at the time of the event, the Retiree must enroll under this special enrollment period in order for his eligible Dependents to enroll.

The Dependent special enrollment period is a period of thirty (30) days and begins on the date of birth, adoption or placement for adoption, or on the date of the marriage. To be eligible for this special enrollment, the Dependent and/or Retiree must request enrollment during this time period as stated above.

The coverage of the Dependent and/or Retiree enrolled in the special enrollment period will be effective:

a. In the case of marriage, the first of the month following enrollment;

b. In the case of a Dependent's birth, as of the date of birth;

c. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption;

TERMINATION OF COVERAGE

The Plan Administrator has the right to rescind any coverage of the Retiree and/or Dependents for cause, including but not limited to making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage or benefits under the Plan. The Plan Administrator may either void coverage for the Retiree and/or covered Dependents for the period of time coverage was in effect, may

terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Retiree's and/or Dependent's paid contributions.

When Coverage Terminates. Coverage will terminate on the earliest of these dates:

1. December 31st, following the annual open enrollment period in which the Covered Person terminates coverage.
2. The effective date of an applicable status change.
3. The date of death for the Covered Person.
4. The end of the month in which eligibility is lost due to a qualified status change.

Loss of Benefits. A Covered Person also may experience a reduction in or loss of benefits in any of the following circumstances:

1. A Covered Person fails to follow the Plan's procedures.
2. The last day of the month in which full payment of premiums was received if the Covered Person ceases to continue making contributions for payments.
3. A Covered Person fails to reimburse the Plan for a claim that was paid in error, or otherwise, but was later denied.
4. A Covered Person receives reimbursement for a Covered Expense by another medical plan that is primary to the Plan while also receiving primary reimbursement from the Plan.
5. A Covered Person receives a judgment, settlement, or otherwise from any person or entity with respect to the Illness, Injury or other condition that gives rise to the expenses the Plan pays.
6. A Covered Person is found to have committed a fraudulent act against the Plan including, but not limited to, the fraudulent filing of a claim for reimbursement.
7. The Plan is amended or terminated, but only with respect to expenses incurred after the amendment or termination becomes effective.

Note: Except in certain circumstances, a covered Dependent may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the COBRA Continuation Coverage section in this Plan.

ARTICLE VI -
MEDICAL BENEFITS

Medical benefits apply when Covered Expenses are Incurred by a Covered Person for care of an Injury or Illness and while the person is covered for these benefits under the Plan.

PAYMENT OF BENEFITS

All benefits under this Plan are payable, in U.S. Dollars, to the Covered Person whose Illness or Injury is the basis of a claim, unless the Covered Person, in accordance with the terms of this Plan, compensates Hospital or Physician of medical care with an assignment of benefits. Payment of benefits from the Plan to a health care Hospital or Physician pursuant to written direction of the Covered Person is subject to the approval of the Plan Administrator and shall be made as consideration in full for services rendered. In the event of the death or incapacity of a Covered Person and in the absence of written evidence to this Plan of the qualification of a guardian for their estate, this Plan may, in its sole discretion, make any and all such payments to the individual or Institution which, in the opinion of this Plan, is or was providing the care and support of such Covered Person.

COVERED EXPENSES

Charges for Covered Expenses are not to exceed the Maximum Allowable Charge that are Incurred for the following items of services and supplies when Medically Necessary to diagnose or treat a Covered Person. These charges are subject to all benefit limits, Exclusions, and other provisions of this Plan. Covered Expenses and Medically Necessary are defined terms; see the Defined Terms section in this Plan for definitions of capitalized terms.

1. **Acupuncture.** Charges for acupuncture subject to the limitations outlined in the Medical Benefits Schedule.

2. **Allergy Testing and Injections.** Covered Expenses will include testing, injections, serum and syringes.

3. **Ambulance (Ground and Air).** Benefits for Covered Expenses incurred by the Covered Person for licensed ground and air ambulance services to, from or between medical facilities for an emergency medical condition are payable as shown on the Medical Benefits Schedule.

   Ambulance and air ambulance services for an emergency medical condition provided by a Non-Network Provider will be covered at the Network Provider benefit level, as specified in the Medical Benefits Schedule. The Covered Person may be required to pay the Non-Network Provider any amount not paid by the Plan, as follows:

   a. For ambulance services, the Covered Person will be responsible to pay the Network Provider Copayment, Deductible and/or Coinsurance. The Covered Person may also be responsible to pay any amount over the Maximum Allowable Charge to a Non-Network Provider. Non-Network Providers have not agreed to accept discounted or negotiated fees, and may bill the Covered Person for charges in excess of the Maximum Allowable Charge; and
   b. For air ambulance services, the Covered Person will only be responsible to pay the Network Provider Copayment, Deductible and/or Coinsurance based on the qualified payment amount.

4. **Ambulatory Surgical Center.** Services of an Ambulatory Surgical Center for Medically Necessary care.

5. **Anesthesia Services.** Anesthesia services provided by a Physician (other than the attending Physician) or Nurse anesthetist including the administration of spinal anesthesia, the injection or inhalation of a drug or other anesthetic agent.

6. **Birthing Center.** Covered Expenses shall include services, supplies and treatments rendered at a birthing center provided the Physician in charge is acting within the scope of their license and the birthing center meets all legal requirements.

7. **Blood and Blood Plasma.** Charges for blood and blood plasma are payable as long as it is not replaced by donation, and administration of blood and blood products including blood extracts or derivatives.

8. **Cardiac Rehabilitation.** Cardiac rehabilitation as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within twelve (12) weeks after other treatment for the medical condition ends; and (d) in a Hospital as defined by this Plan.

9. **Cellular Therapy.** Charges for Medically Necessary cellular therapy.

10. **Chemotherapy**. Charges for chemotherapy, including materials and services of technicians are included.

11. **Chiropractic Care**. Charges for the treatment of an Injury or Illness is payable as outlined in the Medical Benefits Schedule.

12. **Clinical Trials.** Covered Expenses will include charges made for routine patient costs associated with clinical trials approved and sponsored by the federal government. In addition, the following criteria must be met:

    a. The clinical trial is registered on the National Institute of Health (NIH) maintained web site www.clinicaltrials.gov as a Phase I, II, III, or IV clinical trial for cancer treatment.
    b. The Covered Person meets all inclusion criteria for the clinical trial and is not treated "off-protocol."
    c. The Covered Person has signed an informed consent to participate in the clinical trial. The Plan Administrator may request a copy of the signed informed consent;
    d. The trial is approved by the Institutional Review Board of the Institution administering the treatment.
    e. Routine patient costs will not be considered Experimental and/or Investigational and will include costs for services received during the course of a clinical trial, which are the usual costs for medical care, such as Physician visits, Hospital stays, clinical laboratory tests and x-rays that a Covered Person would receive whether or not they were participating in a clinical trial.

    Routine patient costs do not include, and reimbursement will not be provided for:

    - The investigational service, supply, or drug itself; or
    - Services or supplies listed herein as Plan Exclusions; or
    - Services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs). This includes items and services provided solely to satisfy data collection and analysis and that are not used in direct clinical management of the Covered Person; or
    - Services that are clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis; or
    - Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g. device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial Covered Person.

13. **Contraceptives.** All Food and Drug Administration approved contraceptive methods when prescribed by a Physician, including but not limited to, intrauterine devices (IUDs), implants, and injections, and any related Physician and facility charges, including complications, and will be payable under the preventive care benefits.

14. **Cosmetic and/or Reconstructive Surgery.** Cosmetic surgery or reconstructive surgery shall be a Covered Expense provided the surgery is due to bodily injury, infection or other Disease of the involved part or congenital disease or anomaly of a covered Dependent Child which resulted in a functional impairment.

15. **Cranial Banding.** Charges for cranial banding when approved by this Plan.

16. **Dental Injury**. Dental Injury services are payable as shown on the Medical Benefits Schedule and include charges for services for the treatment of an Injury to a sound natural tooth, including but not limited to initial extraction and initial replacement.

    Services for teeth injured as a result of chewing are not covered. Injuries as a result of an act of domestic violence or a medical condition, including both physical and mental health conditions, are a Covered Expense.

    Services must begin within ninety (90) days after the date of the Injury. Services must be completed within twelve (12) months after the date of the Injury.

    Benefits will be paid only for Covered Expenses Incurred for the least expensive service that will produce a professionally adequate result as determined by this Plan.

17. **Diabetes Self-Management Training.** Charges for services and supplies used in Outpatient diabetes self-management programs.

18. **Diagnostic Services and Supplies.** Covered Expenses include, but are not limited to, services and supplies for diagnostic laboratory, pathology, ultrasound, nuclear medicine, magnetic imaging, radiology and oncology, sleep studies, and x-ray.

19. **Durable Medical Equipment (DME).** Charges for Durable Medical Equipment (DME) is payable as shown on the Medical Benefits Schedule provided within a Covered Person's home. Rental is allowed up to, but not to exceed, the total purchase price of the DME. This Plan, at its option, may authorize the purchase of DME in lieu of its rental, if the rental price is projected to exceed the purchase price. Oxygen and rental of equipment for its administration and insulin infusion pumps in the treatment of diabetes are considered DME.

    Repair of DME is a Covered Expense if: (a) the manufacturer's warranty is expired; and (b) repair or maintenance is not a result of misuse or abuse; and (c) maintenance is not more frequent than every six (6) months; and (d) the repair cost is less than the replacement cost.

    Replacement of purchased DME is a Covered Expense if: (a) the manufacturer's warranty is expired; and (b) the replacement cost is less than the repair cost; and (c) the replacement is not due to lost or stolen equipment or misuse or abuse of the equipment; or (d) replacement is required due to a change in condition that makes the current equipment non-functional.

    Duplicate DME is not covered.

20. **Emergency Services.** Coverage is provided for a medical screening examination and associated services to treat a condition that requires immediate medical attention that would reasonably expect to result in: (a) serious jeopardy to the health of an individual (or in the case of a pregnant person, the health of the unborn Child); (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part. Emergency Services include pre-stabilization services that are provided after a patient is moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after a patient is stabilized as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which other Emergency Services are furnished. These services include those provided at an Independent Freestanding Emergency Department as well as a Hospital emergency department. A decision of what

constitutes Emergency Services will not be defined solely on the basis of the Diagnosis but rather will be a determination that takes into account the reasonableness of each situation as defined by a prudent layperson.

21. **Eyeglasses or Contact Lenses.** Charges for the purchase or fitting of eyeglasses or contact lenses following cataract surgery. Charges which were the result of an accident are not covered.

22. **Home Health Care.** Charges for home health care. The maximum weekly benefit for such coverage may not exceed the maximum allowable weekly cost for care in a Skilled Nursing Facility.

    Each visit by a home health care Provider for evaluating the need for, developing a Plan or providing services under a home health care plan will be considered one (1) home health care visit. Up to four (4) consecutive hours of service in a twenty-four (24) hour period is considered one (1) health care visit. A visit by a home health care provider of four (4) hours or more is considered one (1) visit for every four (4) hours or part thereof.

    Home health care provider means an employee of an agency licensed by the proper authority as a home health agency or Medicare approved as a home health agency.

    Home health care will not be reimbursed unless this Plan determines:

    a. Hospitalization or confinement in a Skilled Nursing Facility would otherwise be required if home health care were not provided;
    b. Necessary care and treatment are not available from a family member or other persons residing with the Covered Person; and
    c. The home health care services will be provided or coordinated by a state licensed or Medicare certified home health agency or certified rehabilitation agency.

    The home health care plan consists of: (a) care provided by a nurse; (b) physical, speech, occupational and respiratory therapy; (c) medical social work and nutrition services; and (d) medical appliances, equipment and laboratory services.

    Home health care benefits do not include:

    a. Charges for mileage or travel time to and from the Covered Person's home;
    b. Wage or shift differentials for home health care Providers; and/or
    c. Charges for supervision of home health care Providers.

23. **Hospice Care.** Hospice care is a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in facility settings for a Covered Person suffering from a condition that has a terminal prognosis. **This benefit is only available under the Medical Only Plan.**

24. **Hospital Care.** Hospital services are payable as shown in the Medical Benefits Schedule, and include charges made by a Hospital for daily semi-private, ward, intensive care or coronary care room and board charges for each day of confinement and services furnished for the Covered Person's treatment during confinement.

    Charges for a private or single-bed room are limited to the Maximum Allowable Charge for a semi-private room in the Hospital while confined.

25. **Mastectomy.** Charges for reconstructive services following a covered Mastectomy or Lumpectomy, including, but not limited to:

    a. Reconstruction of the breast on which the Mastectomy or Lumpectomy has been performed.
    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance.

c. Prostheses and physical complications from all stages of Mastectomy or Lumpectomy, including lymphedemas.

The reconstruction of the breast will be done in a manner determined in consultation with the attending Physician and the Covered Person.

This coverage will be subject to the same annual Deductible and Coinsurance provisions that currently apply to Mastectomy or Lumpectomy coverage and will be provided in consultation with the Covered Person and their attending Physician.

26. Maternity Care. Charges for maternity services including normal maternity, c-section and complications.

Group health plans generally may not, under Federal law, 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, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). An attending Provider is defined as an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The definition of attending provider does not include a plan, Hospital, managed care organization or other issuer.

Charges related to Pregnancy for Dependent daughters are covered.

27. Mental or Nervous Disorders and Substance Use Disorder Treatment. Covered Expenses will be payable for care, supplies and treatment of Mental or Nervous Disorders and Substance Use Disorder.

28. Mouth and Teeth Conditions. Charges for dental and oral surgical operations due to Injury or Illness include the following procedures:

a. Excision of partially or completely unerupted impacted teeth. **This benefit is only available under the Medical Only Plan**;
b. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth in conjunction with a pathological examination;
c. Surgical procedures required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
d. Reduction of fractures and dislocations of the jaw;
e. External incision and drainage of cellulitis;
f. Incision of accessory sinuses, salivary glands or ducts;
g. Frenectomy (the cutting of the tissue in the midline of the tongue); and
h. Dental osteotomies.

29. Occupational Therapy. Services provided by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Illness and improve a body function. The Provider must submit a letter of Medical Necessity and all applicable notes. Covered Expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

30. Orthotics. Charges for orthotics that are custom made or custom fitted, and made of rigid or semi-rigid material. Oral or dental splints and appliances must be custom made and for the treatment of documented obstructive sleep apnea. Unless specifically stated otherwise, fabric supports, replacement orthotics and braces, oral splints and appliances, dental splints and appliances, and dental braces are not a Covered Expense.

31. **Physical Therapy.** Services provided by a licensed physical therapist, payable up to the limits as stated in the Medical Benefits Schedule. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. The Provider must submit a letter of Medical Necessity and all applicable notes.

32. **Physician Care.** The professional services of a Physician for surgical or medical services. Surgical reimbursement rates include:

    a. Multiple Surgical Procedures. If multiple or bilateral surgical procedures are performed during the same day, the surgeries will be paid according to the Provider contract for a Network Provider. When a Non-Network Provider is utilized, the surgery with the highest Maximum Allowable Charges monetary amount will be allowed at 100%. For each additional surgery for a Non-Network Provider the amount allowed will be: (i) 50% of the Maximum Allowable Charge for the surgery with the second highest Maximum Allowable Charge monetary amount; and (ii) 25% of the Maximum Allowable Charge for all the other surgeries.
    b. Assistant Surgeon. Services for an assistant surgeon. This Plan will allow the assistant surgeon 16% of the Maximum Allowable Charge for the surgery that would apply if the assistant surgeon were the primary surgeon.
    c. Physician Assistant. Services for a physician assistant (PA). This Plan will allow the PA.10% of the Maximum Allowable Charge for the surgery that would apply if the PA were the primary surgeon.

33. **Preventive Care.** Covered Expenses under medical benefits are payable for routine preventive care as described in the Medical Benefits Schedule. Standard preventive care for adults includes services with an "A" or "B" rating from the United States Preventive Services Task Force or as otherwise identified in applicable law. Examples of standard preventive care include:

    - Screenings for: breast cancer, cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity.
    - Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
    - Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
        - Breastfeeding support, supplies, and counseling.
        - Gestational diabetes screening.

    Standard preventive care includes women's contraceptives sterilization procedures, and counseling.

    Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Illness.

    Charges for Routine Well Child Care. Routine well childcare is routine care by a Physician that is not for an Injury or Illness. Standard preventive care for Children includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of standard preventive care include:

    - Immunizations for Children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:
        - Diphtheria,
        - Pertussis,
        - Tetanus,
        - Polio,
        - Measles,
        - Mumps,
        - Rubella,
        - Hemophilus influenza b (Hib),

- Hepatitis B,
- Varicella.

- Preventive care and screenings for infants, Children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

The list of services included as standard preventive care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html

34. **Private Duty Nursing.** Services of a registered nurse for private duty nursing shall be a Covered Expense up to the limits outlined in the Medical Benefits Schedule.

35. **Prosthetics.** The initial purchase of a prosthesis, including but not limited to, limbs and eyes are payable as shown in the Medical Benefits Schedule. Coverage will be provided for prosthetic devices necessary to restore minimal basic function. Replacement is a Covered Expense if due to pathological changes or growth. Repair of the basic prosthetic device, including replacing a part or putting together what is broken is a Covered Expense.

36. **Radiation Therapy.** Charges for radiation therapy.

37. **Reconstructive Surgery**. Charges for reconstructive surgery due to bodily Injury, infection or other Disease of the involved part or congenital disease or anomaly of a covered Dependent Child which resulted in a functional impairment.

38. **Second Surgical Opinion.** A second surgical opinion obtained with the Plan Administrator's approval. The Provider providing the second opinions MUST NOT be in the same group practice or clinic. If the two opinions disagree, the Covered Person may obtain a third opinion. Benefits for the third opinion are payable the same as for the second opinion. The Provider providing the second or third surgical opinion may confirm the need for surgery or present other treatment options. The decision whether or not to have the surgery is always the Covered Person's.

39. **Skilled Nursing Facility Care**. Charges for expenses Incurred for daily room and board and general nursing services for each day of confinement in a Skilled Nursing Facility are payable as shown in the Medical Benefits Schedule. The daily rate will not exceed the maximum daily rate established for licensed Skilled Nursing Facilities by the Department of Health and Social Services.

    Covered Expenses for a Skilled Nursing Facility confinement are payable when the confinement:

    a. Occurs while the Covered Person is covered under this Plan;
    b. Begins after discharge from a Hospital confinement or a prior covered Skilled Nursing Facility confinement;
    c. Is necessary for care or treatment of the same Injury or Illness which caused the prior confinement; and
    d. Occurs while the Covered Person is under the regular care of a Physician.

    Skilled Nursing Facility means only an Institution licensed as a Skilled Nursing Facility and lawfully operated in the jurisdiction where located. It must maintain and provide:

    a. Permanent and full-time bed care facilities for resident patients;
    b. A Physician's services available at all times;
    c. Twenty-four (24) hour a day skilled nursing services under the full-time supervision of a Physician or registered nurse (R.N.);
    d. A daily record for each patient;
    e. Continuous skilled nursing care for Injury or Illness to Covered Persons during their

convalescence from Illness or Injury; and

f. A utilization review plan.

A Skilled Nursing Facility is not (except by incident), a rest home, a home for care of the aged, or engaged in the care and treatment of Mental or Nervous Disorders or Substance Use Disorders.

40. **Sleep Studies.** Covered Expenses shall include charges for Medically Necessary sleep studies and treatment of sleep apnea and other sleep disorders.

41. **Speech Therapy.** Services provided by a licensed speech therapist, payable up to the limits as stated in the Medical Benefits Schedule. The Provider must submit a letter of Medical Necessity and all applicable notes.

42. **Sterilization Procedures.** Charges for male and female sterilization procedures.

43. **Telehealth Services.** Telehealth services are a Covered Expense which include office visits, psychotherapy, and/or medical consultations via phone, or video conference technology.

44. **Transplant Services.** Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures will be considered Covered Expenses subject to the following conditions:

    a. The following transplant procedures are paid the same as any Illness and are not subject to the transplant provision of this Plan: corneal transplants; implantable prosthetic lenses in connection with cataracts; prosthetic by-pass or replacement vessels; artery or vein transplants; heart valve transplants; and prosthetic joint replacements.
    b. When the recipient is covered under this Plan, the Plan will pay the recipient's Covered Expenses related to the transplant.
    c. When the donor is covered under this Plan, the Plan will pay the donor's Covered Expenses related to evaluating the organ, removing the organ from the donor, transportation of the organ to the place where the transplant is to be performed.
    d. Surgical, storage and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a Covered Expense under this Plan. If a Covered Person's transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement as described above.

    Benefits for organ or tissue donors are limited as outlined in the Medical Benefits Schedule.

    There is no obligation to the Covered Person to use either a Network Provider or a Center of Excellence facility; however, benefits for the transplant and related expenses will vary depending upon whether services are provided by a Network Provider or a Non-Network Provider and whether or not a Center of Excellence facility is utilized. A Center of Excellence is a licensed healthcare facility that has entered into a participation agreement with a national transplant network to provide approved transplant services, at a negotiated rate, to which the Plan has access.

45. **Urgent Care.** Services and supplies provided by an urgent care facility.

46. **Well Newborn Nursery and Physician Care.** Coverage of well newborn nursery and Physician care will be covered as follows:

    Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care, including circumcision, for which a Hospital makes a charge.

This coverage is only provided if the newborn child, who is neither injured nor ill, is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls themself (as well as the newborn child if required) in accordance with the special enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to the Maximum Allowable Charges for nursery care for the newborn child while Hospital confined as a result of the Child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn.

Group health plans generally may not, under Federal law, 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, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Charges for Routine Physician Care. The benefit is limited to the Maximum Allowable Charges made by a Physician for the newborn child while Hospital confined, including circumcision, as a result of the Child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the newborn.

ARTICLE VII -
MEDICAL PLAN EXCLUSIONS

Note: All Exclusions related to Prescription Drugs are shown in the Prescription Drug Benefits section.

The following are not covered under this Plan:

1. **Abortion.** Services, supplies, care or treatment in connection with an elective abortion, unless the life of the mother is endangered by the continued Pregnancy, or the Pregnancy is the result of rape or incest.

2. **Administrative Costs.** Charges for interest, sales tax, or penalties, failure to keep scheduled appointments, completion of a claim form, obtaining medical records, telephone charges or information required to process a claim.

3. **Applied Behavioral Analysis (ABA) Services.** Charges for Applied Behavioral Analysis are not covered under this Plan.

4. **Bariatric Surgery.** A charge for bariatric surgery (including, but not limited to, gastric bypass, intestinal bypass, lap band, Roux-en-Y gastroenterostomy, adjustable gastric restrictive procedure, sleeve gastrectomy, gastroplasty, liposuction, or similar surgeries, including pre- and post-op care.

5. **Biofeedback.** Care, services, supplies and treatment in connection with biofeedback.

6. **Blood.** Charges for blood.

7. **Complications of Non-Covered Expenses.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan. However, complications from abortions, whether elective or non-elective, are covered.

8. **Contraceptives.** Charges for substances or devices, except for any that are specifically covered under the Plan.

9. **Coordination of Benefits.** Benefits available under the Plan that may be reduced or eliminated based upon the coordination of benefits or subrogation rules.

10. **Cosmetic.** Charges that are Incurred in connection with the care and/or treatment of surgical procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent outlined under Covered Expenses. A treatment will be considered cosmetic for either of the following reasons; (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness or congenital abnormality.

11. **Counseling.** Charges for marriage counseling.

12. **Custodial Care.** Charges for Custodial Care, domiciliary care or rest cures.

13. **Deductible.** Charges that are not payable due to the application of any specified Deductible, Copayment or Coinsurance provision of this Plan.

14. **Dental Care.** Charges for dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to any oral surgery, endodontic services or periodontics, implants and related procedures, orthodontic procedures, and any dental services related to a bodily Injury or Illness unless otherwise stated in this Plan.

15. **Donors**. Charges for donor-related health care services and supplies, unless the donor is a Covered Person under the Plan.

16. **Durable Medical Equipment.** Replacement of Durable Medical Equipment within the time specified in the Medical Benefits Schedule unless approved by the Plan Administrator.

17. **Education.** Services for educational or vocational testing or training other than diabetes self-management training, including instruction in alternate life patterns, or training or bed and board from an institution that is primarily a school or other institution for training.

18. **Electrical Power**. Charges for water supply, sanitary waste disposal systems, saunas, hot tubs or swimming pools or their installation or any similar expense associated with a residence.

19. **Excess Charges.** The part of an expense for care and treatment of an Injury or Illness that is in excess of the Maximum Allowable Charge.

20. **Experimental and/or Investigational or not Medically Necessary.** Care and treatment that is either Experimental and/or Investigational, is not Medically Necessary.

21. **Foot Conditions.** Charges for the following types of care of the feet:

    a. Shock wave therapy of the feet;
    b. The treatment of weak, strained, flat, unstable or unbalanced feet;
    c. Hygienic care and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
    d. The treatment of tarsalgia, metatarsalgia or bunion, except surgically;
    e. The cutting of toenails, except the removal of the nail matrix;
    f. Heel wedges, lifts or shoe inserts; and
    g. Arch supports (foot orthotics) or orthopedic shoes, except for diabetes or hammer toe.

22. **Foreign Travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services or prescriptions, unless it is for (a) emergency care; (b) the Covered Person is traveling outside the United States due to employment with the Employer sponsoring the Plan and the services are not covered under any Workers' Compensation or similar law; or (c) the Covered Person and Dependents live outside the United States and the Covered Person is an active status with the Employer sponsoring this Plan.

23. **Gene Therapy**. Charges for gene therapy.

24. **Genetic Testing.** Charges for genetic testing or treatment unless the results are specifically required for a medical treatment decision on the Covered Person or as required by federal law or specifically covered by this Plan.

25. **Government Coverage.** Care, treatment or supplies furnished by or on behalf of the United States government or any other government, unless as to such other government, payment of the charge is legally required. Services or supplies are excluded to the extent benefits for them are provided by any law or governmental program under which the person is or could be covered, unless payment of the charge is legally required.

26. **Hair Loss.** Charges for wigs, artificial hair pieces, artificial hair transplants, or any Prescription Drug or over the counter medical to eliminate baldness.

27. **Hearing Aids and Exams.** Hearing aids, including (but not limited to) semi-implantable hearing devices, audient bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound. Hearing exams are also excluded under this Plan.

28. **Hospice.** Charges for hospice services for Covered Persons enrolled in the Mirror Plan.

29. **Hypnosis.** Charges for hypnosis or hypnotherapy.

30. **Immediate Family Member.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, Child, brother or sister, whether the relationship is by blood or exists in law.

31. **Impacted Wisdom Teeth**. Charges for impacted wisdom teeth for Covered Persons enrolled in the Mirror Plan.

32. **Impotence.** Charges for diagnostic services, surgical and/or non-surgical procedures and Prescription Drugs used to treat impotence.

33. **Infertility and/or Sterility.** Charges for services, supplies or treatment related to the Diagnosis or treatment of infertility and/or sterility and artificial reproductive procedures, including, but not limited to: artificial insemination, invitro fertilization, surrogate mother, fertility drugs when used for treatment of infertility, embryo implantation, or gamete intrafallopian transfer (GIFT).

34. **Late Claims.** Claims not submitted within the Plan's filing limit deadlines.

35. **Medicare.** Benefits available under the Plan that may be reduced or eliminated based upon the coordination of benefits with Medicare when Medicare is the primary payor. This limitation may apply to Covered Persons aged sixty-five (65) or older, unless payment of the charge is legally required.

36. **Midwife.** Charges for services for an unlicensed midwife.

37. **Non-Surgical Treatment of the Spine**. Charges for any non-surgical treatment of the spine.

38. **Not Legally Required to Pay.** Charges for any item for which the Covered Person is not legally required to pay, or for which a charge would not have been made if the Covered Person did not have coverage.

39. **Not Listed.** Any items not listed under Covered Expenses.

40. **Not Necessary.** Charges for services or supplies which are not Medically Necessary for the care of the Covered Person's Illness or Injury, unless otherwise specifically covered under this Plan. This Exclusion includes, but is not limited to, diagnostic services or treatments performed in connection with research studies or pre-marital examinations. The Plan Administrator determines whether a service, treatment or supply is Medically Necessary.

41. **Obesity.** Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment, special diets or diet supplements, appetite suppressants, Nutri System, Weight Watchers or similar programs and Hospital confinements for weight reduction programs except to the extent as required by the Affordable Care Act. Additionally, Charges for bariatric surgery or any surgical weight reduction procedures and all related charges, even if resulting from morbid obesity.

42. **Observation Stays**. Charges for observation stays in a Hospital for Inpatient services when the Covered Person is in observation status.

43. **Occupational Injury.** Any Illness or Injury arising out of, or in the course of, employment with the Covered Person's employer or self-employment, or Illness or Injury covered under the Worker's Compensation Law or any similar legislation.

44. **Oral statements.** Charges which are Incurred based upon oral statements made by anyone involved in the administration of the Plan that are in conflict with the benefits described in this document.

45. **Organ Transplants.** Organ transplants other than those specified as covered under the Plan; or organ transplants that are Experimental and/or Investigational or which are not approved by the FDA; and donor-related health care services and supplies, unless the donor is a Covered Person under the Plan.

46. **Personal or Convenience Items.** Charges for equipment that does not meet the definition of Durable Medical Equipment, including but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-prescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

47. **Prescription Drugs.** Charges for Prescription Drugs and self-administered injectable drugs, whether Inpatient, Outpatient or over the counter, unless specifically referred to as a Covered Expense herein.

48. **Prison.** Charges for services received while confined in a prison, jail or other penal institution.

49. **Radioactive Contamination.** An Injury or Illness caused as a result of radioactive contamination.

50. **Room and Board.** Charges for any other room at the same time the Covered Person is being charged for use of a special care unit.

51. **Services Before or After Coverage.** Care, treatment or supplies for which a charge was Incurred before a person was covered under this Plan or after coverage ceased under this Plan.

52. **Sexual Dysfunctions.** Charges for treatment of sexual dysfunctions including, but not limited to penile implants, sex transformations, gender dysphoria or inadequacies, and sex therapy.

53. **Sleep Disorders.** Charges for care and treatment for sleep disorders, unless deemed Medically Necessary or otherwise specifically covered under the Plan.

54. **Sterilization Reversal.** Care and treatment for reversal of previous sterilization treatments or surgeries.

55. **Temporomandibular Joint Disorder (TMJ).** Charges for diagnostic, surgical and non-surgical treatment of jaw joint problems including temporomandibular joint disorders.

56. **Therapy Services.** Charges for immunotherapy for a recurrent abortion; chemonucleolysis; light treatments for Seasonal Affective Disorder (SAD); immunotherapy for food allergy; prolotherapy; or sensory integration therapy.

57. **Third Party Recovery, Subrogation and Reimbursement.** Charges for Illnesses or Injuries suffered by a Covered Person due to the action or inaction of any party if the Covered Person fails to provide information as specified in the third party recovery, subrogation and reimbursement section of this Plan.

58. **Transplant or Immune Effector Cell Therapy.** Charges for services for or in connection with a transplant or immune effector cell therapy if:

    a. The expense relates to storage of cord blood and stem cells unless it is an integral part of a transplant approved by this Plan.
    b. It is not approved based on established criteria.
    c. Expenses are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received.
    d. The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated as covered in this Plan.

e. The expense relates to the donation or acquisition of an organ or tissue for a recipient who is not covered by this Plan.
f. The expense relates to a transplant or immune effector cell therapy performed outside of the United States and any care resulting from that transplant or immune effector cell therapy. This Exclusion applies even if the Covered Person and Dependents live outside the United States.

59. **Travel or Accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as specifically stated as a benefit under this Plan.

60. **Vax-D Therapy.** Charges associated with Vax-D therapy.

61. **Violation of Law.** The sale, use or administration of any supplies, services or treatment which is in violation of the law, regardless of whether it would otherwise be an eligible expense under the Plan.

62. **Vision Care.** Charges for benefits for Physician services in connection with eye refractions or any other examinations to determine the need for, or the proper adjustment of eyeglasses or contact lenses, unless for the initial examination following cataract surgery. Radial keratomy and any surgical procedures to improve refractive errors such as nearsightedness, etc., are also excluded. This Exclusion does not apply to any services otherwise covered under vision benefits, if any.

63. **Vitamins.** Charges for vitamins, except pre-natal vitamins prescribed by a Physician, minerals nutritional food supplements or any over the counter items, whether or not prescribed by a Physician, unless otherwise specifically covered under this Plan.

64. **War.** Services Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression.

65. **Wigs.** Charges associated with the purchase of a wig, unless otherwise specifically covered under this Plan.

ARTICLE VIII -
CLAIMS PROCEDURES

When services are received from a health care Provider, a Covered Person should show their **identification card** to the Provider.

If it is necessary for a Covered Person to submit a claim, they should request an itemized bill which includes procedure (CPT) and diagnostic (ICD) codes from their health care Provider.

To assist the Claims Administrator in processing the claim, the following information must be provided when submitting the claim for processing:

- A copy of the itemized bill;
- Group name and number;
- Provider Billing Identification Number;
- Employee's name and Identification Number;
- Name of Covered Person;
- Name, address, telephone number of the Provider of care;
- Date of service(s);
- Place of service; and
- Amount billed.

Presentation of a prescription to a Pharmacy does not constitute a claim. If a Covered Person is required to pay the cost of a covered Prescription Drug, they may submit a claim based on that amount to the Claims Administrator.

A general request for an interpretation of Plan provisions will not be considered to be a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of this Plan, should be directed to the Plan Administrator.

Note: A Covered Person can obtain a claim form from the Claims Administrator. Claim forms are also available at:

login.personifyhealth.com

WHERE TO SUBMIT CLAIMS

Claims for expenses should be submitted to the address below:

Personify Health Solutions, LLC
P.O. Box 1590
Covington, LA 70434
(855) 469-0989

WHEN CLAIMS SHOULD BE FILED

Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are Incurred, and in no event later than **456 days** after the claim was Incurred for Non-Network Provider claims, except if the Covered Person was legally incapacitated. Claims should be submitted by a Network Provider in accordance with the timely filing period outlined in that Provider's contract (typically 180 days for Physicians and 90 days for facilities and ancillary Providers, however, a Provider's contractual timely filing period may vary). Plan benefits are only available for claims that are Incurred by a Covered Person during the period that they are covered under this Plan.

The Covered Person must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Covered Person seek a second opinion. The Plan also encourages Covered Persons to obtain second opinions as outlined in the Covered Expenses section set forth above.

The Plan Administrator will only process Clean Claims as defined by this Plan Document.

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

TYPES OF CLAIMS

A **claim** means a request for a Plan benefit, made by a Claimant (Covered Person or by an Authorized Representative of a Covered Person that complies with the Plan's procedures for filing benefit claims).

A Claimant may appoint an Authorized Representative to act upon their behalf with respect to the claim. Only those individuals who satisfy the Plan's requirements to be an Authorized Representative will be considered an Authorized Representative. A healthcare Provider is not an Authorized Representative simply by virtue of an assignment of benefits; however, a healthcare Provider can represent the Claimant in claims involving Urgent Care. Contact the Claims Administrator for information on the Plan's procedures for Authorized Representatives. There are four types of claims:

A **pre-service claim** is a reduction in benefits for certain Covered Services because the Covered Person did not obtain the required Plan approval before receiving the care or treatment.

An **urgent care claim** is any pre-Service claim where the application of the time periods for review and determination of the pre-service claim could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function, or – in the opinion of the Covered Person's treating Physician, would subject the Covered Person to severe pain that cannot be managed without the proposed care or treatment.

A **concurrent care determination** is a reduction or termination of a previously approved course of treatment that is to be provided over a period of time or for a previously approved number of treatments. *If case management is appropriate for a Covered Person, case management is not considered a concurrent care determination.*

A **post-service claim** is a claim for medical care, treatment, or services that a Claimant has already received.

INITIAL BENEFIT DETERMINATION

All questions regarding claims should be directed to the Claims Administrator. All claims will be considered for payment according to the Plan's terms and conditions, limitations and Exclusions, and industry standard guidelines in effect at the time charges were Incurred. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about claims involving specialized medical knowledge or judgment.

A claim will not be deemed submitted until it is received by the Claims Administrator.

The initial benefit determination will be made as follows:

Pre-Service Claims for Urgent Care. If the pre-service claim is determined by the Claims Administrator to be a claim involving urgent care, notice of the Plan's decision will be provided to the Covered Person as soon as possible but no later than 72 hours after receipt of the pre-service claim by the Claims Administrator.

The exception is if the Covered Person does not provide sufficient information to decide the pre-service claim. In that case, notice requesting specific additional information will be provided to the Covered Person within 24 hours of receipt of the pre-service claim.

The Plan's decision regarding the pre-service claim will be made as soon as possible but no later than 48 hours after the earlier of:

- The Plan's receipt of the requested information or
- The expiration of the time period set by the Plan for the requested information (at least 48 hours).

Pre-Service Claims for non-Urgent Care. If the pre-service claim is not an urgent care claim, written notice of the Plan's decision will generally be provided to the Covered Person within a reasonable period of time, but no later than 15 days after receipt of the pre-service claim by the Claims Administrator.

If matters beyond the control of the Claims Administrator so require, one 15-day extension of time for processing the pre-service claim beyond the initial 15 days may be taken. Written notice of the extension will be furnished to the Covered Person before the end of the initial 15-day period. If an extension is required because the Covered Person did not provide the information necessary to make a determination on the claim, the notice of extension will specifically describe the required information.

The time-period for processing the pre-service claim will be deferred beginning on the date this extension notice is sent to the Covered Person and ending on the earlier of:

- The date the Plan receives a response to the request for additional information, or
- The date set by the Plan for a response (which will be at least 45 days).

Concurrent Care Determination. The initial benefit determination on a concurrent care determination will be made within 15 days of the Claim Administrator's notice of a concurrent care claim. If additional information is necessary to process the concurrent care claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant or the healthcare Provider must submit the requested information within 45 days of receipt of the request from the Claims Administrator. Failure to submit the requested information within the 45-day period may result in a denial of the claim or a reduction in benefits.

If additional information is requested, the Plan's time period for making a determination on a concurrent care claim is suspended until the earlier of:

- The date the Plan receives the Claimant's or healthcare Provider's response for additional information, or
- The date set by the Plan for the Claimant or healthcare Provider to respond (which will be at least 45 days).

A benefit determination on the concurrent care claim will be made within 15 days of the Plan's receipt of the additional information.

Post-Service Claim. The initial benefit determination on a post-service claim will be made within 30 days of the Claim Administrator's receipt of the claim. If additional information is necessary to process the claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. Failure to submit the requested information within the 45-day period may result in a denial of the claim or a reduction in benefits.

If additional information is requested, the Plan's time period for making a determination on a post-service claim is suspended until the earlier of:

- The date the Plan receives the Claimant's additional information; or
- The date set by the Plan for the Claimant to respond (which will be at least 45 days).

A benefit determination on the claim will be made within 15 days of the Plan's receipt of the additional information.

NOTICE OF DETERMINATION

1. The Plan shall provide written or electronic notice of the determination on a claim in a manner meant to be understood by the Claimant. If a claim is denied in whole or in part, notice will include the following:
2. Specific reason(s) for the denial.
3. Reference to the specific Plan provisions on which the denial was based.
4. Description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
5. Description of the Plan's claims review procedures and the time limits applicable to such procedures. This will include a statement of the Claimant's right to bring a civil action following a notice of the determination on final review.
6. Statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

If applicable:

1. Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the claim (or a statement that such a rule, guideline, protocol, or criterion was relied upon in making the notice of the determination and that a copy will be provided free of charge to the Claimant upon request).
2. If the notice of the determination is based on the Medical Necessity or Experimental and/or Investigational Exclusion or similar such Exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the claim, or a statement that such explanation will be provided free of charge, upon request.
3. Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a claim.

If the Claimant has questions about the denial, the Claimant may contact the Claims Administrator at the address or telephone number printed on the notice of determination.

An Adverse Benefit Determination also includes a rescission of coverage, which is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively, or is a retroactive cancellation or discontinuance because of the Covered Person's failure to timely pay required premiums.

CLAIMS REVIEW PROCEDURE - GENERAL

A Claimant may appeal an Adverse Benefit Determination as follows:

- The Plan offers a one-level internal review process for pre-service claims for urgent care; or
- The Plan offers a two-level internal review procedure for a pre-service claim (non-urgent care), concurrent care claim, and post service claim.

The Plan Administrator will provide for a review that does not give deference to the previous benefit determination and that is conducted by either an appropriate plan fiduciary or the Claims Administrator on the Plan's behalf who was not involved in any of the prior determinations. In addition, the Plan Administrator may:

- Take into account all comments, documents, records and other information submitted by the Claimant related to the claim, without regard as to whether this information was submitted or considered in a prior level of review.
- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon or created by the Plan in connection with the claim. This information or new rationale will be provided

sufficiently in advance of the response deadline for the final notice of the determination so that the Claimant has a reasonable amount of time to respond.

- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant's benefit determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is "independent" to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the initial benefit determination.

Note: Providers who have submitted claims to the Plan that are subject to the NSA, cannot avail themselves to the internal and external claims procedure set forth herein. All disputes regarding all payments for claims subject to NSA must be resolved through open negotiating or through a Certified Independent Dispute Resolution (IDR) Entity as outlined in the NSA.

INTERNAL APPEAL PROCEDURE

First Level of Internal Review. To appeal a denial of a claim, the Claimant must submit in writing, a request for a review of the claim. The Claimant should include in the appeal letter: their name, ID number, group health plan name, and a statement of why the Claimant disagrees with the denial. The Claimant may include any additional supporting information, even if not initially submitted with the claim.

The written request for review must be submitted within 180 days of the Claimant's receipt of an Adverse Benefit Determination.

The written request for review should be addressed to:

Claims Administrator
Personify Health Solutions, LLC
Attn: Appeals
P.O. Box 1590
Covington, LA 70434

An appeal will not be deemed submitted until it is received by the Claims Administrator. Failure to appeal the initial denial within the prescribed time period will render that determination final. The Claimant cannot proceed to the next level of internal or external review if the Claimant fails to submit a timely appeal.

The first level of review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant and determine if the initial benefit determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic notice of determination to the Claimant within:

- 72 hours of the receipt of the appeal for an urgent care claim;
- 15 days of the receipt of the appeal for a pre-service claim or a concurrent care claim; or
- 30 days of the receipt of the appeal for a post service claim.

Second Level of Internal Review

If the Claimant does not agree with the Claims Administrator's determination from the first level of internal review, the Claimant may submit a second level appeal in writing. The Claimant may request a second level appeal on pre-service claims (non-urgent care) and post-service only along with any additional supporting information.

The written request for review of the first level of internal review must be submitted within 60 days of the Claimant's receipt of the first level of internal review.

The written request for review should be addressed to:

Claims Administrator
Personify Health Solutions, LLC
Attn: Appeals
P.O. Box 1590
Covington, LA 70434

An appeal will not be deemed submitted until it is received by the Plan Administrator or the Claims Administrator on the Plan Administrator's behalf. Failure to appeal the determination from the first level of review within the prescribed time period will render that determination final. The Claimant cannot proceed to an external review or file suit if the Claimant fails to submit a timely appeal.

The second level of internal review will be done by the Plan Administrator, or its designee. The Plan Administrator will review the information initially received and any additional information provided by the Claimant, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator will send a written or electronic Final Internal Adverse Benefit Determination for the second level of review to the Claimant within:

- 15 days of the Plan's receipt of Claimant's second level appeal on a pre-service claim (non-urgent care);
- 15 days of the Plan's receipt of Claimant's second level appeal on a concurrent care determination; or
- 30 days of the Plan's receipt of Claimant's second level appeal on a post-service claim.

If the Claimant is not satisfied with the outcome of the final determination on the second level of internal review, the Claimant may be eligible for an external review. The Claimant must exhaust both levels of the internal review procedure before requesting an external review. In certain circumstances, the Claimant may also request an expedited external review.

EXTERNAL REVIEW PROCEDURE

This Plan has an external review procedure that provides for a review conducted by a qualified Independent Review Organization (IRO) that shall be assigned on a random basis.

A Claimant may, by written request made to the Plan within 4 months from the date of receipt of the notice of the final internal Adverse Benefit Determination or the 1st of the fifth month following receipt of such notice, whichever occurs later, request a review by an IRO of a final Adverse Benefit Determination of a claim, except where such request is limited by applicable law.

A request for external review may be granted only for Adverse Benefit Determinations that involve a:

- Determination that a treatment or services is not Medically Necessary;
- Determination that a treatment is Experimental and/or Investigational;
- Rescission of coverage, whether or not the rescission involved a claim; or
- Determination on whether the Plan is complying with the No Surprises Act, as applicable.

For an Adverse Benefit Determination to be eligible for external review, the Claimant must complete the required forms to process an external review. The Claimant may contact the Claims Administrator for additional information.

The Claimant will be notified in writing within 6 business days as to whether Claimant's request is eligible for external review and if additional information is necessary to process Claimant's request. If Claimant's request is determined ineligible for external review, notice will include the reasons for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process Claimant's request, Claimant may submit the additional information within the four-month filing period, or 48 hours, whichever occurs later.

Claimant should receive written notice from the assigned IRO of Claimant's right to submit additional information to the IRO and the time periods and procedures to submit this additional information. The IRO will make a final determination and provide written notice to the Claimant and the Plan no later than 45 days from the date the IRO receives Claimant's request for external review. The notice from the IRO should contain a discussion of its reason(s) and rationale for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision.

The decision of the IRO is binding upon the Plan and the Claimant, except to the extent other remedies may be available under applicable law.

Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the notice of determination on the final level of internal or external review, whichever is applicable.

Generally, a Claimant must exhaust the Plan's Claims Procedures in order to be eligible for the external review process. However, in some cases the Plan provides for an expedited external review if**:**

1. The Claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal claims and appeal procedures would seriously jeopardize the Claimant's life or health or ability to regain maximum function and the Claimant has filed a request for an expedited internal review; or

2. The Claimant receives a final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard external review process would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, or if the final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, the Plan must determine and notify the Claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for external review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the Claimant and the Plan.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

A Covered Person may designate another individual to be an Authorized Representative and act on their behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed and dated by the Covered Person, and include all the information required in the Authorized Representative form. The appropriate form can be obtained from the Plan Administrator or the Claims Administrator. The Plan does not recognize the appointment of an Authorized Representative by any other instrument.

Should a Covered Person designate an Authorized Representative, all future communications from the Plan will be conducted with the Authorized Representative instead of the Covered Person, unless the Plan Administrator is otherwise notified in writing by the Covered Person. A Covered Person can revoke the Authorized Representative designation at any time. A Covered Person may authorize only one person as an Authorized Representative at a time.

Recognition as an Authorized Representative is completely separate from a Provider accepting an assignment of benefits, requiring a release of information, or requesting completion of a similar form. An assignment of benefits by a Covered Person shall not be recognized as a designation of the Provider as an Authorized Representative.

CONDITIONS AND LIMITATIONS OF AN ASSIGNMENT OF BENEFITS

The validity of an assignment of benefits by a Covered Person to a Provider is limited by the terms of this Plan Document. An assignment of benefits is considered valid on the condition that the Provider accepts the payment received from the Plan as consideration, in full, for Covered Expenses. This amount does not include any cost sharing amounts (i.e. Copayments or Coinsurance), or charges for non-Covered Expenses; the Provider may bill the Covered Person directly for these amounts.

A Provider with a valid assignment of benefits does **not** have the right to exhaust, on behalf of the Covered Person, the administrative remedies available under this Plan. This right is reserved exclusively for the Covered Person or their Authorized Representative. An assignment of benefits by a Covered Person to a Provider will not constitute the appointment of an Authorized Representative. The Covered Person does not, under any circumstances, have the right to assign to any Provider (or their representative) through an assignment of benefits any right to initiate any cause of action against the Plan that the Covered Person them self may be afforded under applicable law and the terms of the Plan. This includes, but is not limited to, any right to bring suit as such is afforded to Covered Persons. The assignment of any right to initiate suit against the Plan to a Provider is strictly prohibited.

An assignment of benefits does not grant the Provider any rights other than those specifically set forth herein.

The Plan Administrator may disregard an assignment of benefits at its discretion and continue to treat the Covered Person as the sole recipient of the benefits available under the terms of the Plan.

By submitting a claim to the Plan and accepting payment by the Plan, the Provider is expressly agreeing to the foregoing conditions and limitations of an assignment of benefits in addition to the terms of the Plan Document. The Provider further agrees that the payments received constitute an "accord and satisfaction" and consideration in full for the Covered Expenses rendered. The Provider agrees that the conditions and limitations of an assignment of benefits as set forth herein shall supersede any previous terms and/or agreements. The Provider agrees to the specific condition that the Covered Person may not be balance billed for any amount beyond applicable cost sharing amounts (i.e. Copayments or Coinsurance), or charges for non-Covered Expenses; the Provider may bill the Covered Person directly for these amounts.

If a Provider refuses to accept an assignment of benefits under the conditions and limitations as set forth herein, any benefits payable under the terms of the Plan Document will be payable directly to the Covered Person and the Plan will be deemed to have fulfilled its obligations with respect to such Covered Expenses.

CONTACT INFORMATION

A Covered Person may contact the commissioner and the Kentucky Consumer Protection Division for assistance at any time using the contact information below:

Grievance and Appeals
Kentucky Consumer Protection Division
P.O. Box 14546
Lexington, KY 40512-4546

IF A COVERED PERSON HAS QUESTIONS ON INTERNAL CLAIMS AND APPEALS AND EXTERNAL REVIEW RIGHTS.

For more information on internal claims and appeals and external review rights, contact the Department of Health and Human Services Health Insurance Assistance Team (HIAT) at (888) 393-2789.

STATE CONSUMER ASSISTANCE OR OMBUDSMAN TO ASSIST WITH INTERNAL CLAIMS AND APPEALS AND EXTERNAL REVIEW PROCESSES.

A state office of consumer assistance or ombudsman is available to assist the Covered Person with internal claims and appeals and external review processes. The contact information is as follows:

Kentucky Department of Insurance, Consumer Protection Division
P.O. Box 517
Frankfort, KY 40602
http://healthinsurancehelp.ky.gov.
DOI.CAPOmbudsman@ky.gov.

ARTICLE IX -
COORDINATION OF BENEFITS

BENEFITS SUBJECT TO THIS PROVISION

Benefits described in this Plan are coordinated with benefits provided by other plans under which the Covered Person is also covered. This is to prevent duplication of coverage and a resulting increase in the cost of medical coverage.

For this purpose, a plan is one which covers medical or dental expenses and provides benefits or services by group, franchise or blanket insurance coverage. This includes group-type contracts not available to the general public, obtained and maintained only because of the Covered Person's membership in, or connection with, a particular organization or group, whether or not designated as franchise, blanket, or in some other fashion. Plan also includes any coverage provided through the following:

- Employer, trustee, union, employee benefit, or other association; or
- Governmental programs, programs mandated by state statute, or sponsored or provided by an educational institution.

This Coordination of Benefits provision does not apply to any individual policies or blanket student accident insurance provided by, or through, an educational institution. Allowable Expense means any eligible expense, a portion of which is covered under one of the plans covering the person for whom claim is made. Each plan will determine what is an Allowable Expense according to the provisions of the respective plan. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

EFFECT ON BENEFITS

One of the plans involved will pay benefits first. This is called the primary plan. All other plans are called secondary plans.

ORDER OF BENEFIT DETERMINATION

In order to pay claims, it must be determined which plan is primary and which plan(s) are secondary. A plan will pay benefits first if it meets one of the following conditions:

- The Plan has no coordination of benefits provision;
- The Plan covers the person as an employee;
- For a Child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the calendar year pays before the plan covering the other parent. If the birthdates of both parents are the same, the plan which has covered the person for the longer period of time will be determined the primary plan.

If a plan other than this Plan does not include the final bullet above, then the gender rule will be followed to determine which plan is primary.

In the case of Dependent Children covered under the plans of divorced or separated parents, the following rules apply:

- The plan of a parent who has custody will pay the benefits first;
- The plan of a step-parent who has custody will pay benefits next;
- The plan of a parent who does not have custody will pay benefits next;
- The plan of a step-parent who does not have custody will pay benefits next.

There may be a court decree which gives one parent financial responsibility for the medical or dental expenses of the Dependent Children. If there is a court decree, the rules stated above will not apply if they conflict with the court decree. Instead, the plan of the parent with financial responsibility will pay benefits first.

If a person is laid off or is retired or is a Dependent of such person, that plan covers after the plan covering such person as an active employee or Dependent of such 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 will be ignored.

If the above rules do not apply or cannot be determined, then the plan that covered the person for the longest period of time will pay first.

GENERAL COORDINATION OF BENEFITS WITH MEDICARE

When permitted by law, this Plan is the secondary plan. If the Covered Person is covered under both Medicare and this Plan, federal law mandates that Medicare is the secondary plan in most situations. In all cases, coordination of benefits with Medicare will conform to federal statutes and regulations and benefits under this Plan will be coordinated to the extent benefits are payable under Medicare, as allowed by federal statutes and regulations. The benefits of this Plan may be reduced by the full amount of Medicare benefits the Covered Person is entitled to receive, whether or not actually enrolled in Medicare.

RIGHT OF RECOVERY

This Plan reserves the right to recover benefit payments made for an Allowable Expense under this Plan in the amount which exceeds the maximum amount this Plan is required to pay under these provisions. This right of recovery applies to this Plan against:

- Any person(s) to, for or with respect to whom, such payments were made; or
- Any other insurance companies, or organizations which according to these provisions, owe benefits due for the same Allowable Expense under any other plan.

This Plan alone will determine against whom this right of recovery will be exercised.

ARTICLE X -
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, 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, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Covered Person(s), their attorney, and/or 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 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first- and third-party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be 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 Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

Subrogation. As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its Authorized Representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Covered Person(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.

2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

3. Any policy of insurance from any insurance company or guarantor of a third party.

4. Workers' compensation or other liability insurance company.

5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

The Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person's/Covered Persons' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement. The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Covered Person(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Covered Person(s) is fully compensated by their recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way 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 and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Covered Person's/Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

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 Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, Disease or disability.

Covered Person is a Trustee Over Plan Assets. Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement,

judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Covered Person understands that they are required to:

1. Notify the Plan or its Authorized Representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.

2. Instruct their attorney to ensure that the Plan and/or its Authorized Representative is included as a payee on all settlement drafts.

3. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its Authorized Representative as a payee on the settlement draft.

4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which they exercise control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over Plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability. The Plan's right to reimbursement extends to any incident related care that is received by the Covered Person(s) (Incurred) prior to the liable party being released from liability. The Covered Person's/Covered Persons' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Covered Person has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

Separation of Funds. Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Reimbursement Due to Surrogacy Arrangement. If a Covered Person enters into a Surrogacy Arrangement, the Covered Person must reimburse the Plan for Covered Expenses received related to conception, Pregnancy, delivery, or postpartum care in connection with that Surrogacy Arrangement. The reimbursed amount shall not exceed the payments or other compensation the Covered Person or another person is entitled to receive under the Surrogacy Arrangement.

A "Surrogacy Arrangement" is one in which a Covered Person agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the Child (or Children), whether or not the Covered Person receives payment for being a surrogate.

A Surrogacy Arrangement does not affect a Covered Person's obligation to pay any and all patient responsibility amounts for these services. These amounts will be taken into account at the time of reimbursement.

After a Covered Person surrenders a baby to the legal parents, the Plan is not obligated to pay for any services that the baby receives (the legal parents are financially responsible for any services that the baby receives).

As set forth above, as a condition precedent to the Covered Person receiving benefits under the Plan, the Covered Person automatically assigns to the Plan any right to receive payments that are payable to the Covered Person or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure the Plan's rights, the Plan will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy the Plan's lien.

Within 30 days after entering into a Surrogacy Arrangement, the Covered Person must send written notice of the arrangement to the Plan, including all of the following information:

1. Names, addresses and telephone numbers of all parties to the arrangement;

2. Names, addresses and telephone numbers of any escrow or trustee;

3. Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for the services of baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover the services that the baby (or babies) receive;

4. A signed copy of any contracts and other documents explaining the details of the Surrogacy Arrangement; and

5. Any other information the Plan requests in order to satisfy its rights.

Information must be sent to:

Claims Administrator
Personify Health Solutions, LLC
P.O. Box 1590
Covington, LA 70434
(855) 469-0989

The Covered Person must complete and send the Plan all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for the Plan to determine the existence of any rights the Plan may have under this Surrogacy Arrangement and to satisfy those rights. The Covered Person may not agree to waive, release, or reduce the Plan's rights without the Plan's prior, written consent.

If a Covered Person's estate, parent, guardian, or conservator asserts a claim against a third party based on the Surrogacy Arrangement, the estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to the Plan's liens and other rights to the same extent as if the Covered Person had asserted the claim against the third party. The Plan may assign its rights to enforce its liens and/or other rights.

Wrongful Death. In the event that the Covered Person(s) dies as a result of their injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

Obligations. It is the Covered Person's/Covered Persons' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.

2. To provide the Plan with pertinent information regarding the Illness, Disease, disability, or Injury, including Accident reports, settlement information and any other requested additional information.

3. To take such action and execute such documents as the Plan may require facilitating enforcement of its subrogation and reimbursement rights.

4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.

5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.

6. To notify the Plan or its Authorized Representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.

7. To notify the Plan or its Authorized Representative of any settlement prior to finalization of the settlement.

8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.

9. To instruct their attorney to ensure that the Plan and/or its Authorized Representative is included as a payee on any settlement draft.

10. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its Authorized Representative as a payee on the settlement draft.

11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

If the Covered Person(s) and/or their attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person's/Covered Persons' cooperation or adherence to these terms.

Offset. If timely repayment is not made, or the Covered Person and/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 deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

Minor Status. In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and 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 court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation. The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

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 Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

ARTICLE XI -
COBRA CONTINUATION COVERAGE

INTRODUCTION

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Only qualified beneficiaries may elect to continue their group health plan coverage under the Plan. A qualified beneficiary is a Retiree, spouse of a Retiree, or Dependent Child of a Retiree who will lose coverage under the Plan because of a qualifying event. (Certain newborns, newly adopted children and alternate recipients under Qualified Medical Child Support Orders ["QMCSOs"] may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Continuation coverage is the same coverage that the Plan makes available to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including special enrollment rights. For more information about rights and obligations under the Plan, contact the Plan Administrator**.**

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage otherwise would end because of a life event. This is also known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Covered Persons could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

QUALIFYING EVENTS

The Retiree will become a qualified beneficiary if they lose their coverage under the Plan because their retirement benefits end within the COBRA maximum coverage period for any reason other than their gross misconduct. The spouse of a Retiree, will become a qualified beneficiary if they lose their coverage under the Plan because any of the following qualifying events:

- The Retiree dies;
- The Retiree's benefits end within the COBRA maximum coverage period for any reason other than their gross misconduct;
- The Retiree becomes enrolled in Medicare (Part A, Part B or both); or
- The spouse becomes divorced or legally separated from the Retiree.

Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The Retiree dies;
- The Retiree's retirement benefits end within the COBRA maximum coverage period for any reason other than their gross misconduct;
- The Retiree becomes enrolled in Medicare (Part A, Part B or both);
- The parents become divorced or legally separated; or
- The Child stops being eligible for coverage under the Plan as a Dependent Child.

NOTIFICATION OF QUALIFYING EVENTS

The Covered Person is responsible for providing notice to the Plan Administrator when certain qualifying events occur. If the Covered Person does not provide notice within certain timeframes, they will not be entitled to continuation coverage under the Plan. The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the death of the Retiree, or enrollment of the Retiree in Medicare (Part A, Part B or both), the Retiree or the Retiree's family must notify the Plan Administrator of such qualifying event as soon as possible, but not later than thirty (30) days of any of the following events:

- Divorce or legal separation of the Retiree and spouse;
- The Dependent Child loses coverage;
- The occurrence of a second qualifying event; or
- Determination of Social Security disability status, the affected qualified beneficiary, or the Covered Person's representative must notify the Plan Administrator.

The Plan requires the Covered Person to notify the Plan Administrator in writing within sixty (60) days after the later of:

- The qualifying event;
- The date the qualified beneficiary loses (or would lose) coverage due to the qualifying event, or the date the qualified beneficiary is informed of the responsibility to provide notice and the Plan's procedures for providing notice, using the procedures specified in the section below titled "Notice Procedures." If these procedures are not followed, or if the notice is not provided in writing to the Plan Administrator during the sixty (60) day notice period, any spouse or Dependent Child who loses coverage will NOT BE OFFERED THE OPTION TO ELECT CONTINUATION COVERAGE.

Note: Medicare entitlement means that Covered Persons are eligible for and enrolled in Medicare.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any Retiree covered under the Plan, the Retiree will become a qualified beneficiary. The Retiree's spouse and Dependent Children also will become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment, death of the covered Retiree, commencement of proceeding in bankruptcy with respect to the Employer (for covered retirees only), or the covered Retiree's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the qualifying event.

For all other qualifying events (divorce or legal separation of the Retiree and spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), Covered Persons must notify the Plan Administrator within 60 days after the qualifying event occurs. This notice must be provided in writing to:

Plan Administrator
Kentucky Public Pensions Authority
1260 Louisville Road
Frankfort, KY 40601
(502) 696-8800

Notice must be postmarked (if mailed) or dated (if emailed or hand-delivered) on or before the 60th day following the qualifying event.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Retirees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their Children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying even during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which the 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of Cobra Continuation Coverage. If a Retiree or Dependent covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and they notify the Plan Administrator in a timely fashion, as outlined below, Covered Persons may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months.

The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a qualifying event occurs;
- The date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; or
- The date on which the qualified beneficiary is informed, through the furnishing of the Plan's Summary Plan Description of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18-months of COBRA continuation coverage.

The notice must include the name of the qualified beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

Covered Persons must provide this notice to:

Plan Administrator
Kentucky Public Pensions Authority
1260 Louisville Road
Frankfort, KY 40601
(502) 696-8800

Second Qualifying Event Extension of 18-Month Period of Cobra Continuation Coverage. If a Covered Person experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in the family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second qualifying event. This extension may be available to the spouse and any Dependent Children receiving COBRA continuation coverage if the covered Retiree or former Retiree dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan. This extension is only available if the second qualifying event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

Notice of a second qualifying event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant qualifying event occurs;
- The date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; or
- The date on which the qualifying beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the qualified beneficiary experiencing the second qualifying event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

Covered Persons must provide this notice to:

Plan Administrator
Kentucky Public Pensions Authority
1260 Louisville Road
Frankfort, KY 40601
(502) 696-8800

DOES COBRA CONTINUATION COVERAGE EVER END EARLIER THAN THE MAXIMUM PERIODS ABOVE?

COBRA continuation coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date the Employer ceases to provide a group health plan to any Retiree;
- The date on which coverage ceases by reason of the qualified beneficiary's failure to make timely payment of any required premium;
- The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as a Retiree or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules;
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA Covered Person.

HOW DOES ONE PAY FOR COBRA CONTINUATION COVERAGE?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the group health plan for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150%). The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage.

If a Covered Person has questions about these new tax provisions, call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is available at www.doleta.gov/tradeact.

PAYMENT FOR CONTINUATION COVERAGE

First payment for continuation coverage if the Covered Person elects continuation coverage, they do not have to send any payment for continuation coverage with the election form. However, they must make their first payment for continuation coverage within 45 days after the date of their election. This is the date the election form is postmarked, if mailed. If the Covered Person does not make their first payment for continuation coverage within those 45 days, they will lose all continuation coverage rights under the Plan. The Covered Person's first payment must cover the cost of continuation coverage from the time their coverage under the Plan would have otherwise terminated. Covered Persons are responsible for making sure that the amount of their first payment is enough to cover this entire period. Humana has contracted with WEX Benefits to administer COBRA benefits for the Plan. The COBRA premium payment amounts and the mailing address for the COBRA premiums will be stated on the election form provided at the time of the Covered Person's COBRA qualifying event. Questions concerning premium payments should be directed to WEX Benefits at 1- 877-765-8810.

PERIODIC PAYMENTS FOR CONTINUATION COVERAGE

After the Covered Person makes their first payment for continuation coverage, they will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the first day of the month for the month in which the payments apply. If a Covered Person makes a periodic payment on or before its due date, their coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods. Periodic payments for continuation coverage should be sent to the address indicated on the election form provided at the time of the COBRA qualifying event.

OPTION TO ELECT OTHER HEALTH COVERAGE BESIDES COBRA CONTINUATION COVERAGE

The Covered Person may have the right, when their group health coverage ends, to enroll in an individual health insurance policy, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. The Covered Person may exercise this right in lieu of electing continuation coverage, or they may exercise this right after they have received the maximum continuation coverage available to them. The Covered Person should note that if they enroll in an individual conversion policy, they could lose their right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when their conversion policy coverage ends.

MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES (CHILDREN BORN OR PLACED FOR ADOPTION WITH THE COVERED RETIREE DURING COBRA PERIOD)

A child born to, adopted by or placed for adoption with a covered Retiree during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered Retiree is a qualified beneficiary, the covered retiree has elected continuation coverage for himself or herself. The Child's COBRA coverage begins when the Child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the Retiree. To be enrolled in the Plan, the Child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

ALTERNATE RECIPIENTS UNDER QMCSOs

A Child of the covered Retiree who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) is entitled to the same rights under COBRA as a Dependent Child of the covered Retiree. The covered Retiree must properly designate the Child who is receiving benefits under the Plan pursuant to a QMCSO as a Dependent with Kentucky Public Pensions Authority.

ADDITIONAL INFORMATION

Additional information about the Plan and COBRA continuation coverage is available from the Plan Administrator or the COBRA Administrator:

Plan Administrator
Kentucky Public Pensions Authority
1260 Louisville Road
Frankfort, KY 40601
(502) 696-8800

COBRA Administrator:
WEX Benefits
3216 13th Avenue S.
Fargo, ND 58103
(877) 765-8810

CURRENT ADDRESSES

Let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. Covered Persons should also keep a copy, for their records, of any notices sent to the Plan Administrator.

ARTICLE XII -
RESPONSIBILITIES FOR PLAN ADMINISTRATION & PLAN MANAGEMENT

The Plan is administered by the Plan Administrator in accordance with the provisions of any applicable state laws. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible. The Plan Administrator may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

The Plan Administrator shall establish the policies, practices and procedures of this Plan. The Plan Manager shall administer this Plan in accordance with its terms. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Manager as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator, in its discretion, that the Covered Person is entitled to them.

- **The Plan Manager is Humana Insurance Company. Humana has contracted with Personify Health to provide certain delegated administrative duties, including the processing of claims. The Claims Fiduciary is:**

Personify Health Solutions, LLC
P.O. Box 1590
Covington, LA 70434
(855) 469-0989

If, due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, shall be considered ambiguous and shall be interested by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may amend retroactively to cure such ambiguity, notwithstanding anything in the Plan to the contrary.

DUTIES OF THE PLAN ADMINISTRATOR

The duties of the Plan Administrator include the following:

1. To determine all questions of eligibility, status and coverage under the Plan;
2. To make factual findings;
3. To decide disputes which may arise relative to a Covered Person's rights;
4. To keep and maintain the Plan Documents and all other records pertaining to the Plan;
5. To appoint and supervise a Claims Administrator to pay claims;
6. To perform all necessary reporting as required by applicable state laws.
7. To establish and communicate procedures to determine whether a Medical Child Support Order or National Medical Support Notice is a QMCSO;
8. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and

9. To perform each and every function necessary for or related to the Plan's administration.

DUTIES OF THE PLAN MANAGER

1. To administer the Plan in accordance with its Terms

2. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;

3. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;

4. To approve, in its sole discretion, payment of, or reimbursement for, Covered Expenses rendered by a Provider which has agreed to a charge for its services that are less than, or equal to, the charges that would otherwise be paid by the Plan; provided, reimbursement to a Covered Person for a Provider that accepts only cash payments from the Covered Person, shall be subject to the applicable Deductibles, Copayments or out-of-pocket requirements of the Plan;

5. To negotiate or approve contracts with specific Providers as the Plan Manager deems is in the best interest of the Plan; including payment of a different amount payable under the Plan, taking into consideration specific circumstances;

6. To adjust, settle, contest, compromise and arbitrate any claims debts or damages due and owing to or from the Plan, and to sue, commence or defend any legal proceedings in reference thereto. If the Plan Manager considers it in the best interest of the Plan, they may abstain from enforcing any right, obligation or claim, or abandon any property held by the plan; and

7. To impose limitations of benefits and/or Providers as the Plan Manager deems necessary or appropriate to ensure the fiscal viability of the Plan; provided, such limitations shall be applied in a uniform and consistent manner to all persons in similar circumstances.

Plan Administrator Compensation. The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

Fiduciary. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties. A fiduciary must carry out their duties and responsibilities for the purpose of providing benefits to the Retirees and their Dependent(s) and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

1. With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

2. By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

3. In accordance with the Plan Documents to the extent that they agree with any applicable state laws.

The Named Fiduciary. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. The named fiduciary has violated its stated duties in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

2. The named fiduciary breached its fiduciary responsibility.

Claims Fiduciary. The Plan Manager has contracted with the Claims Fiduciary to provide certain delegated administrative duties, including the processing of claims.

ARTICLE XIII -
FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Retiree Coverage: Funding is derived from contributions made to the Kentucky Public Pensions Authority Group Health Plan by the covered Retirees and Employer contributions.

For Dependent Coverage: Funding is derived from contributions made by the covered Retirees.

The level of any Retiree contributions will be set by the Employer. These Retiree contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Retiree.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or Institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Covered Person, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination.

The Plan Sponsor or Plan Administrator reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

DISTRIBUTION OF ASSETS

Subject to the requirements of any applicable laws in the event of a termination or partial termination of the Plan or Trust (if applicable), Kentucky Public Pensions Authority shall direct the disposition of Plan assets pursuant to applicable law and governing documents, including assets held in a Trust, if any, which may include transfer of such assets to another retiree benefit plan or trust maintained by an Employer.

ARTICLE XIV -
HIPAA PRIVACY AND SECURITY

STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

DISCLOSURE OF SUMMARY HEALTH INFORMATION TO THE PLAN SPONSOR

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

Summary Health Information may be individually identifiable health information, and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO THE PLAN SPONSOR FOR PLAN ADMINISTRATION PURPOSES

Protected Health Information (PHI) means individually identifiable health information, created or received by a health care Provider, health plan, Employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Retiree benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

4. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

5. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

6. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

7. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

8. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or

Retiree of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

10. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)) is established as follows:

    a. The following persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

        - **Privacy officer; and**
        - **Other individuals trained and authorized by the privacy officer to receive PHI.**

    b. The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

    c. In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non- compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

        "Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

DISCLOSURE OF CERTAIN ENROLLMENT INFORMATION TO THE PLAN SPONSOR

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

DISCLOSURE OF PHI TO OBTAIN STOP-LOSS OR EXCESS LOSS COVERAGE

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards and any applicable Business Associate Agreement(s).

OTHER DISCLOSURES AND USES OF PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

CONTACT INFORMATION

Privacy Officer Contact Information:
Privacy Officer
Kentucky Public Pensions Authority
1260 Louisville Road
Frankfort, KY 40601
(502) 696-8800

STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (THE "SECURITY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

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

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

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;

3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and

4. Report to the Plan any security incident of which it becomes aware.

ARTICLE XV -
GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan, and the administration is provided through a Claims Administrator. The funding for the benefits is derived from contributions by Kentucky Public Pensions Authority and contributions made by the covered Retirees. The Plan is not insured.

PLAN NAME: Kentucky Public Pensions Authority Group Health Plan

PLAN NUMBER: 501

TAX ID NUMBER: 61-0600439

PLAN EFFECTIVE DATE: January 1, 2025

PLAN YEAR: January 1st through December 31st

GRANDFATHER STATUS: Grandfathered

APPLICABLE LAW: Applicable state, local or federal laws.

PLAN SPONSOR

Kentucky Public Pensions Authority on behalf of the Kentucky
Retirement Systems and the County Employees Retirement System
1260 Louisville Road
Frankfort, KY 40601
(502) 696-8800

PLAN ADMINISTRATOR

Kentucky Public Pensions Authority
1260 Louisville Road
Frankfort, KY 40601
(502) 696-8800

PLAN MANAGER

Humana Insurance Company
500 West Main Street
Louisville, KY 40202

NAMED FIDUCIARY

Board of the Kentucky Public Pensions Authority
1260 Louisville Road
Frankfort, KY 40601
(502) 696-8800

AGENT FOR LEGAL PROCESS
(In addition, service of legal process may be made upon the Plan Administrator.)

Kentucky Public Pensions Authority
1260 Louisville Road
Frankfort, KY 40601
(502) 696-8800

CLAIMS ADMINISTRATOR

Personify Health Solutions, LLC
P.O. Box 1590
Covington, LA 70434
(855) 469-0989

CLAIMS FIDUCIARY

Personify Health Solutions, LLC
P.O. Box 1590
Covington, LA 70434
(855) 469-0989