WELFARE EMPLOYEE BENEFIT PLAN DOCUMENTS

for

USD #262 VALLEY CENTER

Documents prepared by:

HINKLE

LAW FIRM LLC

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USD #262 VALLEY CENTER

WELFARE BENEFIT PLAN

PLAN DOCUMENTS AND ADMINISTRATIVE FORMS

HINKLE LAW FIRM LLC

USD #262 VALLEY CENTER - SUMMARY OF WELFARE BENEFIT PLAN ELIGIBILITY INFORMATION

Plan Name	Plan Funding	Insurance Company	Contract Number	Eligibility Conditions (hours per week)	Entry Date	Policy Anniversary	Plan Year	Premiums Paid
Welfare Benefit Plan	N/A	N/A	N/A	Regularly scheduled to work at least 20 hours per week. Except that anyone that is classified as a "substitute" must be regularly scheduled to work at least 30 hours per week.	1st day of the month following date of hire.	N/A	April 1-March 31	N/A
Medical Plan (non-grandfathered)	Fully-Insured	Blue Cross Blue Shield of Kansas	09327	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	April 1	April 1-March 31	Part Employer Paid, part Employee Paid on a Pre-Tax basis through Welfare Benefit Plan.
Dental Plan	Fully-Insured	Delta Dental of Kansas	52109/52110	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	April 1	April 1-March 31	Employee Paid on a Pre-Tax basis through Welfare Benefit Plan.
Health Flexible Spending Account	Self-Funded	Claims Administrator: Surency	N/A	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	September 1	September 1-August 31	Pre-Tax basis through Welfare Benefit Plan.
Dependent Care Assistance Plan	Self-Funded	Claims Administrator: Surency	N/A	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	September 1	September 1-August 31	Pre-Tax basis through Welfare Benefit Plan.

USD #262 VALLEY CENTER - SUMMARY OF WELFARE BENEFIT PLAN ELIGIBILITY INFORMATION

Plan Name	Plan Funding	Insurance Company	Contract Number	Eligibility Conditions (hours per week)	Entry Date	Policy Anniversary	Plan Year	Premiums Paid
Vision Plan	Fully-Insured	Surency Life and Health	52110010 52109010	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	April 1	April 1-March 31	Employee Paid on a Pre-Tax basis through Welfare Benefit Plan.
Group Life Plan	Fully-Insured	Lincoln Financial	000010133119	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	April 1	April 1-March 31	Employer Paid; Employee not taxed on premium.
Voluntary Life Plan (includes AD&D)	Fully-Insured	Lincoln Financial	000400001000-1373	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	April 1	April 1-March 31	Employee Paid on an After Tax basis.
Short Term Disability Plan	Fully-Insured	Lincoln Financial	000010147074	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	April 1	April 1-March 31	Employee Paid on an After Tax basis.
Accident Plan	Fully-Insured	Allstate	20216	Same as Welfare Benefit Plan.	April 1 following date of hire.	April 1	April 1-March 31	Employee Paid on an After-Tax basis.
Critical Illness Plan	Fully-Insured	Allstate	20216	Same as Welfare Benefit Plan.	April 1 following date of hire.	April 1	April 1-March 31	Employee Paid on an After-Tax basis.
Cancer Plan	Fully-Insured	Allstate	20216	Same as Welfare Benefit Plan.	April 1 following date of hire.	April 1	April 1-March 31	Employee Paid on an After-Tax basis.

USD #262 VALLEY CENTER

WELFARE BENEFIT PLAN

USD #262 VALLEY CENTER
WELFARE BENEFIT PLAN

USD #262 Valley Center ("Employer") adopts this amended and restated USD #262 Valley Center Welfare Benefit Plan ("Plan") for the benefit of its Eligible Employees. This Plan is an amendment and restatement of the Plan originally adopted effective July 1, 1989, as subsequently amended and restated effective April 1, 2015.

ARTICLE I
PURPOSE AND LEGAL STATUS OF THE PLAN

Section 1.01 Purpose of Plan. The purpose of this Plan is to provide Eligible Employees of the Employer a choice between taxable compensation and nontaxable benefits, and after-tax benefits offered by the Employer. Additionally, this Plan provides certain Employer-Paid Benefits to Eligible Employees of the Employer.

Section 1.02 Plan Status. It is the intent of the Employer that this Plan qualify as a "cafeteria plan" within the meaning of Section 125 of the Internal Revenue Code, as amended, and the regulations issued thereunder, and that any "qualified benefits" paid under this Plan be eligible for exclusion from the Participant's gross income for federal income tax purposes.

Section 1.03 Exclusive Benefit. It is intended that the Plan terms, including those related to coverage and benefits, be legally enforceable and that this Plan be maintained for the exclusive benefit of Employees and their covered dependents.

Section 1.04 Status of Plan. It is the intent of the Employer that this Plan, including any underlying Benefit Package Options, be considered to be a single plan. For purposes of COBRA continuation rights, however, each underlying Benefit Package Option shall be considered to be a separate plan.

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ARTICLE II
DEFINITIONS

Section 2.01 "After-Tax Benefit" means one (1) or more of the following plans:

(a) USD #262 Valley Center Voluntary Life Plan ("Voluntary Life Plan");

(b) USD #262 Valley Center Short Term Disability Plan ("Short Term Disability Plan"); and

(c) USD #262 Valley Center Allstate After-Tax Plan ("Allstate After-Tax Plan").

Section 2.02 "Annual Enrollment Period" means the period defined in Section 5.03(b) of this Plan.

Section 2.03 "Benefit Package Option" means a benefit that is offered under this Plan on a pre-tax basis or an option for coverage that is offered under an underlying accident or health plan (such as an indemnity option, an HMO option, or a PPO option under an accident or health plan).

Section 2.04 "Claim" means any formal request for a Plan benefit or benefits made by a Claimant or his/her representative in accordance with the Plan's procedures for filing benefit claims as set forth in Article IX and/or Appendix C. A Claim does not include a request for a determination of an individual's eligibility to participate in the Plan, nor does it include a casual inquiry regarding the scope of coverage under the Plan. A communication regarding benefits that is not made in accordance with the Plan's procedures for filing a Claim will not be treated as a Claim.

Section 2.05 "Claimant" means a Participant who files a Claim for benefits pursuant to Article IX and/or Appendix C of this Plan.

Section 2.06 "Claims Administrator" means the Plan Administrator, unless the Employer retains another person to serve as the claims fiduciary for a Pre-Tax Benefit choice, After-Tax Benefit choice, or an Employer-Paid Benefit choice with the authority to grant or deny claims for benefits.

Section 2.07 "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

Section 2.08 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

Section 2.09 "Compensation" means wages, salary and other remuneration paid to a Participant by the Employer, but does not include amounts contributed by the Employer to a qualified plan, other than elective deferrals made to a 401(k) plan or 403(b) plan or arrangements on behalf of the Participant, and does not include any other fringe benefits or medical benefits provided by the Employer.

Section 2.10 "Effective Date" means the original date on which this Plan took effect, which date is July 1, 1989; provided, however, that if this Plan is subsequently amended, such new or amended provisions shall be effective on such later date as shall be determined by the Employer.

Section 2.11 "Election Change Event" means an event which would allow a Participant to change the Participant's elections during a Plan Year, subject to the requirements of Article V and as set forth in more detail in Sections 5.06 through 5.16.

Section 2.12 "Eligible Employee" means an individual who is actively employed by the Employer in a regularly scheduled work week ordinarily equaling or exceeding twenty (20) hours per week, except that anyone who is classified as a "substitute" employee (a category that includes, but is not limited to, substitute teachers, substitute bus drivers, substitute custodians, substitute food service, substitute aides, substitute secretaries) must be regularly scheduled to work at least thirty (30) hours per week, subject to the following:

(a) Special Rules:

(i) *Seasonal Employees*. Seasonal Employees are not Eligible Employees under this Plan;

(ii) *Status During Leaves of Absence.* An Employee's status as an Eligible Employee shall be deemed to continue during any paid leave of absence approved by the Employer; during an unpaid leave of absence not to exceed the end of the month; or, if the FMLA is applicable to the Employer, during a leave of absence taken pursuant to the FMLA;

(iii) *Status During Military Service.* An Employee ceases to be an Eligible Employee during the period of time such Employee enters active service in the armed forces of any country, except for temporary active service of two (2) weeks or less; and

(iv) *Medical, Dental, and/or Vision Plans.* An Eligible Employee who is participating in the Medical, Dental and/or Vision Plans and who terminates employment with the Employer before the end of the month will continue to participate in this Plan for purposes of participating in the Medical, Dental, and/or Vision Plans on a pre-tax basis through the end of the month in which the termination occurs.

(b) The following shall not be an Eligible Employee: any individual who is, with respect to the Employer, (i) a self-employed individual, or (ii) a two percent (2%) shareholder of an S corporation under Section 1372(b) of the Code; provided, however, that any individual encompassed by this Subsection (b) shall be an Eligible Employee only for purposes of participating in an underlying After-Tax Benefit, an Employer-Paid Benefit, or *on an after-tax basis* in an underlying Pre-Tax Benefit.

Note: The Pre-Tax Benefits, After-Tax Benefits, and Employer-Paid Benefits may have additional eligibility requirements. Such additional requirements, if any, are set forth separately in this Plan document.

Section 2.13 "Employee" means an individual employed by the Employer, excluding those persons covered by a collective bargaining agreement and further excluding those persons classified by the Employer on its payroll records as "leased employees" as that term is used in Section 414(n) of the Code.

Section 2.14 "Employer" means USD #262 Valley Center.

Section 2.15 "Employer-Paid Benefit" means the USD #262 Valley Center Group Life Plan ("Group Life Plan").

Section 2.16 "FMLA" means the Family and Medical Leave Act of 1993, as amended from time to time.

Section 2.17 "Group Health Plan" means, for purposes of the HIPAA, COBRA, and FMLA provisions in Articles III, V, VII, and VIII, a Pre-Tax Benefit, an After-Tax Benefit, or an Employer-Paid Benefit that provides health care to the Participants in the Plan and their beneficiaries. The term includes the following benefits:

(a) USD #262 Valley Center Medical Plan ("Medical Plan");

(b) USD #262 Valley Center Dental Plan ("Dental Plan");

(c) USD #262 Valley Center Health Flexible Spending Account ("Health FSA"); and

(d) USD #262 Valley Center Vision Plan ("Vision Plan").

Section 2.18 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Section 2.19 "Participant" means an Eligible Employee who has entered the Plan pursuant to Section 3.01 and whose participation in the Plan has not been terminated pursuant to Section 3.02.

Section 2.20 "Plan" means the USD #262 Valley Center Welfare Benefit Plan.

Section 2.21 "Plan Administrator" means the Employer. The Employer may designate from time to time one (1) or more individuals or other persons to carry out various administrative and other duties with respect to this Plan in a manner consistent with the terms of this Plan.

Section 2.22 "Plan Year" means the fiscal year of this Plan, the twelve (12) consecutive month period beginning every April 1 and ending the subsequent March 31, except that the Plan Year for the Health FSA and Dependent Care Assistance Plan is September 1-August 31.

Section 2.23 "Pre-Tax Benefits" means one (1) or more of the following:

(a) USD #262 Valley Center Medical Plan;

(b) USD #262 Valley Center Dental Plan;

(c) USD #262 Valley Center Health Flexible Spending Account;

(d) USD #262 Valley Center Dependent Care Assistance Plan ("DCAP"); and

(e) USD #262 Valley Center Vision Plan.

Section 2.24 "Seasonal Employee" means an employee who is hired into a position for which the customary annual employment is six (6) months or less.

Section 2.25 "Spouse" means a person of the same or opposite sex to whom an Eligible Employee is legally married under the laws of the jurisdiction in which the marriage was entered into (as such laws existed at the time of marriage), regardless of whether the marriage would be recognized by the jurisdiction in which the couple currently resides. A common law marriage shall be considered to be a legal marriage if the common law marriage was validly entered into in a state that recognizes common law marriage. The Plan Administrator shall have the authority to determine whether a person is a Spouse, including the authority to request such documents as may be necessary, in its discretion, to establish the existence of a legal marriage (including the existence of a common law marriage). An individual will not be considered a "Spouse" for purposes of this Plan if (a) his/her marriage to the Eligible Employee has been terminated by a court having jurisdiction over one (1) or both parties to the marriage or (b) either party to the marriage is also lawfully married to another (third) person under the laws recognized by any state.

Section 2.26 "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

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ARTICLE III
PARTICIPATION IN THE PLAN

Section 3.01 Entry into the Plan.

(a) *General Rule.* An Eligible Employee becomes a Participant on the first day of the month following date of hire.

An Eligible Employee who has entered into the Plan pursuant to this Section is a Participant without regard to whether he/she elects to reduce his/her Compensation in order to purchase benefits under one (1) or more of the Pre-Tax Benefits and/or After-Tax Benefits.

(b) *Effective Date of this Plan.* Notwithstanding any other provision of this Plan, no Eligible Employee may become a Participant prior to the Effective Date of this Plan.

(c) *Rehired Participants.* If a Participant terminates employment, is later rehired, and becomes an Eligible Employee after being rehired, the former Participant will again become a Participant in the Plan pursuant to the provisions of Section 3.01(a). The elections of a former Participant who reenters the Plan within thirty (30) days after the date on which he/she ceased to be a Participant are subject to the provisions of Section 5.21.

Section 3.02 Termination of Participation.

(a) *General Rule.* A Participant will cease participation in this Plan on the earlier of the following dates:

(i) The date on which this Plan terminates; or

(ii) The date on which the Participant ceases to be an Eligible Employee.

Although a Participant's participation under this Plan terminates on the above date, coverage or benefits under the Pre-Tax, After-Tax, and Employer-Paid Benefits may continue if, and to the extent, provided by such Pre-Tax, After-Tax, and Employer-Paid Benefits.

Section 3.03 Family and Medical Leave Act of 1993.

(a) *General Rule.* Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the FMLA, the Employer will, to the extent required by the FMLA, continue to maintain the Participant's benefits under a Group Health Plan on the same terms and conditions as though the Participant were still an active Employee (that is, the Employer will continue to pay its share of the premium to the extent the Participant opts to continue his/her coverage). If the Participant is a participant in the Health FSA, additional rules may apply to the Participant's coverage under the Health FSA as set forth in the Appendix for the Health FSA.

(b) *Options for Payment of Participant's Share of the Premium.* If the Participant opts to continue his/her coverage, the Participant may pay his/her share of the premium in one (1) or more of the following ways:

(i) The Participant may pay his/her share of the premiums with after-tax dollars while on leave (or with pre-tax dollars to the extent the Employee receives Compensation during the leave).

(ii) The Participant may pay his/her share of the premium pursuant to such other arrangement as may be agreed upon between the Participant and the Plan Administrator.

(c) *Return from FMLA Leave.* If the Participant's coverage ceases while the Participant is on FMLA leave, the Participant will be permitted to reenter the Plan immediately upon his/her return from FMLA leave on the same basis that the Participant was participating in the Plan prior to his/her leave, or as otherwise required by the FMLA.

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ARTICLE IV
OPTIONAL BENEFITS

Section 4.01 Pre-Tax Benefits. Each Participant may elect to reduce his/her Compensation and have the amount applied by the Employer toward the cost of benefits available under one (1) or more of the Pre-Tax Benefits under this Plan. For those benefits that are provided through a policy of insurance, the monthly premiums are determined by the applicable insurance company and may change from time to time.

(a) *Terms and Conditions of the Pre-Tax Benefits.* The terms and conditions of the Pre-Tax Benefits are as follows:

(i) *Medical Plan*. Participants may elect to receive medical coverage through the Medical Plan. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix A.

(ii) *Dental Plan*. Participants may elect to receive dental coverage through the Dental Plan. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix B.

(iii) *Health Flexible Spending Account.* Participants may elect to make contributions to the Health FSA. A Health FSA enables Participants to elect pre-tax salary reduction and receive reimbursements for their unreimbursed Qualified Medical Expenses incurred during a Plan Year. The Employer intends that this benefit qualify under Section 105(h) of the Code so that the Employer's reimbursements from the Health FSA are excludable from the Participant's gross income. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix C.

(iv) *Dependent Care Assistance Plan*. Participants may elect to make contributions to the DCAP. A DCAP enables Participants to elect pre-tax salary reduction and receive reimbursements for their Qualified Dependent Care Expenses incurred during a Plan Year. The Employer intends that this benefit qualify under Section 129 of the Code so that the Employer's reimbursements from the DCAP are excludable from the Participant's gross income. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix D.

(v) *Vision Plan*. Participants may elect to receive vision coverage through the Vision Plan. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix E.

(b) *Election of Pre-Tax Benefits.* The election of a Pre-Tax Benefit is subject to the terms and conditions of Article V.

(c) *Cessation of Participation in a Pre-Tax Benefit.* Except as otherwise expressly provided in the Pre-Tax Benefit, a Participant will cease to be a participant in the Pre-Tax Benefit on the date that he/she ceases to be a Participant in this Plan.

Section 4.02 After-Tax Benefits. Each Participant may elect to have the cost of one (1) or more of the After-Tax Benefits deducted from his/her Compensation on an after-tax basis. The monthly premiums for insurance coverage are determined by the applicable insurance company and may change from time to time.

(a) *Terms and Conditions of the After-Tax Benefits.* The terms and conditions of the After-Tax Benefits are as follows:

(i) *Voluntary Life Plan*. Participants may elect to receive life insurance through the Voluntary Life Plan. The terms and conditions of this After-Tax Benefit are provided in Appendix G.

(ii) *Short Term Disability Plan*. Participants may elect to receive short term disability insurance through the Short Term Disability Plan. The terms and conditions of this After-Tax Benefit are provided in Appendix H.

(iii) *Allstate After-Tax Plan*. Participants may elect to receive accident coverage, critical illness coverage, and/or cancer coverage through individual policies or group contracts, as applicable, under the Allstate After-Tax Plan. The terms and conditions of this After-Tax Benefit Choice are provided in Appendix I.

(b) *Election of After-Tax Benefits.* A Participant may make and/or change his/her elections with respect to an After-Tax Benefit at any time in accordance with the rules and procedures established by the Plan Administrator. Any such election change shall take effect on the earliest administratively practicable date after the request to change an after-tax election is received by the Plan Administrator.

Section 4.03 Employer-Paid Benefit. In addition to the optional benefits set forth in Sections 4.01 and 4.02, the Employer may choose to provide selected benefits to its Eligible Employees. Except as otherwise expressly provided in the Employer-Paid Benefit below, a Participant will cease to be a participant in such Employer-Paid Benefit on the date that he/she ceases to be a Participant in this Plan. The Group Life Plan (Appendix F) is an Employer-Paid Benefit.

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ARTICLE V
ELECTION OF PRE-TAX BENEFITS

Section 5.01 Benefit Plans. Each Participant may elect to receive the Participant's entire Compensation in cash or to reduce the Participant's Compensation and have the Employer apply the amount by which the Participant's Compensation is reduced toward the cost of benefits that are available on a pre-tax basis under this Plan.

Section 5.02 Method of Making an Election. In order to purchase a Pre-Tax Benefit through this Plan, a Participant must execute an agreement to reduce his/her Compensation on the salary reduction form provided by the Plan Administrator. The Plan Administrator may require such agreement to be completed and submitted in electronic form through the use of the Internet, an Intranet, a telephone system, or such other system as the Plan Administrator may prescribe.

Section 5.03 Timing of Elections.

(a) *Initial Elections for New Participants.* To make an election to purchase Pre-Tax Benefits through this Plan, a new Participant must execute a salary reduction form and deliver it to the Plan Administrator no later than thirty (30) days after the date the Participant becomes a Participant in this Plan.

(b) *Annual Elections for Current Participants.* At least thirty (30) days prior to the beginning of each Plan Year, the Plan Administrator must provide each Participant with the opportunity to make elections for the following Plan Year. Participants desiring to make elections during the Annual Enrollment Period for the next Plan Year must do so in the manner and within the deadlines prescribed by the Plan Administrator. Elections made during the Annual Enrollment Period shall become effective for the following Plan Year.

(c) *Election Changes during a Plan Year.* A Participant may change his/her elections with respect to a Pre-Tax Benefit during a Plan Year *only if* an election change is permitted as a result of one (1) or more of the events listed in Sections 5.06 through 5.16. Such events may be referred to generally in Plan documents as an "Election Change Event." Except as otherwise provided in this Article V, any election change as a result of an event qualifying as an Election Change Event must be made no later than thirty (30) days after the event. Election changes made as a result of an Election Change Event may *not* be given retroactive effect except as specifically set forth below. Additional restrictions and/or rules may apply to election changes made during a Plan Year with respect to a Health FSA and/or a DCAP.

Section 5.04 Failure to Make an Election.

(a) *Failure to Make Initial Election.* A Participant's failure to return a completed salary reduction form by the required date as set forth in Section 5.03(a) constitutes an election to receive the Employee's entire Compensation for the Plan Year in cash.

In such an event, no portion of the Employee's Compensation will be applied toward the cost of any benefits available under any of the Pre-Tax Benefits. Such an Employee will not be permitted to change such an election until (i) the next Annual Enrollment Period *or* (ii) the Employee experiences an Election Change Event, as a result of which an election change would be permitted under this Article V.

(b) *Failure to Change Existing Elections During Annual Enrollment Period.* Once a Participant has completed a salary reduction form for a Plan Year, a failure to complete a new form for a subsequent Plan Year during the Annual Enrollment Period constitutes an election to receive the Employee's entire Compensation for the Plan Year in cash.

Section 5.05 Irrevocability of an Election Once Made. Once the Annual Enrollment Period has passed, a Participant shall not be permitted to revoke, amend, or change the elections the Participant has made for the affected Plan Year except as provided in this Article V.

Section 5.06 Election Change Due to Change in Status. After a Plan Year has commenced, a Participant shall be permitted to revoke an election in its entirety (or revoke the election and make a new election) for the balance of that Plan Year, if the Participant experiences a Change in Status as defined below and the consistency requirements of this Section are satisfied.

(a) *Change in Status*. The following events constitute a Change in Status:

(i) *Change in Marital Status.* A change in the Participant's legal marital status, including the following: marriage, divorce, the death of a Spouse, legal separation, and annulment.

(ii) *Change in Number of Dependents.* A change in the number of the Participant's dependents, including the following: birth, death, adoption, and placement for adoption.

(iii) *Change in Employment Status.* Any of the following events that change the employment status of the Participant, the Participant's Spouse, or the Participant's dependents:

(A) A termination or commencement of employment;

(B) A commencement of or return from an unpaid leave of absence;

(C) A change in worksite, if such a change affects eligibility under this Plan or a Pre-Tax Benefit;

(D) A change in employment status, such as a change from salaried to hourly employment, if the change affects the eligibility of the Participant, the Participant's Spouse, or the Participant's

dependents under this Plan or under a Pre-Tax Benefit or if the change affects the eligibility of the Participant, the Participant's Spouse, or the Participant's dependents under a cafeteria plan or welfare benefit plan maintained by an employer (other than the Employer) employing the Participant, the Participant's Spouse, or the Participant's dependents; or

(E) A strike or lockout.

(iv) *Change in Dependent Eligibility.* An event that causes the Participant's dependent(s) to satisfy or cease to satisfy the eligibility conditions for coverage under a Pre-Tax Benefit on account of the dependent's attainment of a certain age, student status, or any similar circumstances.

(v) *Change in Residence.* A change in the place of residence of the Participant, the Participant's Spouse, or the Participant's dependent(s), if such a change affects eligibility under this Plan or a Pre-Tax Benefit.

(b) *Consistency*. An election change that is made on account of a Change in Status must be consistent with that Change in Status. Whether a particular election change is consistent with a Change in Status will be determined by the Plan Administrator in accordance with Internal Revenue Service ("IRS") regulations.

Section 5.07 Election Change Due to Exercise of HIPAA Special Enrollment Rights.

(a) *HIPAA Special Enrollment Rights.* After a Plan Year has commenced, a Participant may revoke his/her prior election for health coverage and make a new election for such coverage, if the Participant, the Participant's Spouse, or a dependent of the Participant is entitled to special enrollment rights under a group health plan of the Employer as described under either (i), (ii), (iii), or (iv) below:

(i) *Eligibility for a State Premium Assistance Subsidy under the Plan from Medicaid or SCHIP.* A Participant or his/her Spouse or dependent becomes eligible for a state premium assistance subsidy under a group health plan of the Employer from either Medicaid or a state's children's health insurance program (SCHIP);

(ii) *Loss of Eligibility for Medicaid or SCHIP Coverage.* The Medicaid or SCHIP coverage of a Participant or his/her Spouse or dependent is terminated as a result of a loss of eligibility;

(iii) *Loss of Other Coverage.* Medical coverage was declined under a group health plan sponsored by the Employer because the Employee and/or dependent was covered under another group health plan or had other health insurance coverage, and eligibility for such coverage is subsequently lost. A loss of eligibility for such other coverage includes the following:

(A) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period;

(B) Loss of eligibility for coverage through an HMO in the individual market because the individual no longer resides, lives, or works in a service area (whether or not the choice of the individual); and

(C) In the case of coverage offered through an HMO in the group market that does not provide benefits to an individual who no longer resides, lives, or works in the service area (whether or not the choice of the individual), and no other benefit package is available to the individual.

A loss of eligibility does not include a loss resulting from the failure of the Employee or dependent to pay premiums on a timely basis or a termination of coverage for cause (e.g., fraud).

(iv) *Acquisition of a New Dependent.* The Participant acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption.

(b) *New Election Must Correspond and be Consistent with HIPAA Special Enrollment Rights.* A change in elections pursuant to this Section must correspond and be consistent with the exercise of the special enrollment rights provided under Code § 9801(f).

(i) *Increase in Salary Reductions.* A Participant may elect to increase the amount by which his/her Compensation is reduced by no more than the additional cost of the benefits provided under the group health plan as a result of the enrollment of the Participant, the Participant's Spouse, and/or a dependent of the Participant in the group health plan.

(ii) *Decrease in Salary Reductions.* A Participant may elect to decrease the amount by which his/her Compensation is reduced by no more than the cost of the premium assistance received by the Participant and/or his/her dependents.

(iii) *Election to Add Previously Eligible Dependents.* An election to add previously eligible dependents as a result of a loss of other coverage or the acquisition of a new Spouse or dependent child shall be considered to be consistent with the special enrollment rights.

(c) *Status Change Form.* Each Participant must complete a status change form and submit such form to the Plan Administrator no later than sixty (60) days after the date of the event giving rise to the exercise of a HIPAA special enrollment right under (a)(i) or (a)(ii) above, or no later than thirty (30) days after the date of the event giving rise to the right to exercise the special enrollment rights under (a)(iii) or (a)(iv) above.

(d) *Effective Date of Medicaid/SCHIP Provisions.* The effective date of the HIPAA special enrollment right provisions set forth in Subsections (a)(i) and (a)(ii) is April 1, 2009.

(e) *Approval of Change.* Any change in election resulting from the exercise of the special enrollment rights provided under Code § 9801(f) is subject to the review and approval of the Plan Administrator.

Section 5.08 Election Change Due to Mid-Year Enrollment in a Qualified Health Plan Under the Marketplace. After a Plan Year has commenced, a Participant may revoke his/her prior election for health coverage and make a new election for such coverage if the Participant enrolls in a Qualified Health Plan through the Health Insurance Marketplace (commonly referred to as the "Exchange" or "Marketplace"), established by the Patient Protection & Affordable Care Act, by virtue of having become eligible for a special enrollment period in the Marketplace or having enrolled during the Marketplace's annual open enrollment period, so long as both of the following conditions are satisfied:

(a) The revocation of the Participant's election corresponds to the intended enrollment of the Participant, and any Spouse or dependents who cease coverage due to the revocation, in a Qualified Health Plan through the Marketplace; and

(b) The new coverage under the Marketplace's Qualified Health Plan in which the Participant (and, if applicable, the Participant's Spouse and/or dependents) enrolls takes effect no later than the day immediately following the day that the Participant's coverage under the Medical Plan is terminated. (The Plan Administrator may rely on the Participant's reasonable representation regarding the intention to enroll in a Qualified Health Plan under the Marketplace and the effective date of such coverage.)

Section 5.09 Election Change Due to Change in Coverage (Does not apply to Health FSA).

(a) *Cessation or Significant Curtailment in Coverage.*

(i) *Significant Curtailment Without Loss of Coverage.* If the Plan Administrator determines that coverage under a Benefit Package Option is significantly curtailed (but not lost) during the Plan Year, the Participant may revoke his/her election for coverage under that Benefit Package Option and may elect coverage, on a prospective basis only, under another Benefit Package Option providing similar coverage. Coverage under a plan is deemed "significantly curtailed" only if there is an overall reduction in coverage provided to Participants under the plan so as to constitute reduced coverage to Participants in general.

(ii) *Significant Curtailment With Loss of Coverage.* If the Plan Administrator determines that coverage under a Benefit Package Option is significantly curtailed during the Plan Year and that the curtailment constitutes a loss of coverage with respect to a Participant (or the Participant's Spouse or

dependent), the Participant may revoke his/her election for coverage under that Benefit Package Option and may elect coverage, on a prospective basis only, under another Benefit Package Option providing similar coverage. If no similar Benefit Package Option is available, the Participant may elect to drop coverage. For purposes of this Section 5.09(a)(ii), a loss of coverage means a complete loss of coverage under the Benefit Package Option or other coverage option (including the elimination of a Benefits Package Option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion and in accordance with prevailing IRS guidance, may determine that the following constitutes a loss of coverage:

(A) A substantial decrease in the medical care providers available under the option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO);

(B) A reduction in the benefits for a specific type of medical condition or treatment with respect to which the Participant or the Participant's Spouse or dependent is currently in a course of treatment; or

(C) Any other similar fundamental loss of coverage.

(iii) *Determinations to be Made by the Plan Administrator.* The Plan Administrator, in its sole discretion, shall decide, in accordance with prevailing IRS guidance and based upon the surrounding facts and circumstances, whether a curtailment is "significant," whether a curtailment represents a loss of coverage with respect to a particular individual, and whether a substitute Benefit Package Option provides "similar coverage."

(b) *Addition or Improvement of a Benefit Package Option.* If, during the Plan Year, a new Benefit Package Option or a new coverage option is added, or if coverage under an existing Benefit Package Option or existing coverage option is significantly improved during the period of coverage, a Participant may elect to add the new Benefit Package Option/coverage option, or the improved Benefit Package Option/coverage option, and to make corresponding changes with respect to other Benefit Package Options providing similar coverage. Any such change will take effect on a prospective basis only. The Plan Administrator, in its sole discretion, shall decide, based upon the surrounding facts and circumstances and in accordance with prevailing IRS guidance, whether a new Benefit Package Option/coverage option has been added, whether an existing Benefit Package Option/coverage option has been significantly improved, and/or whether another Benefit Package Option/coverage option constitutes "similar coverage."

(c) *Change in Coverage of Spouse or Dependent under Plan of Another Employer ("Election Lock").* After the Plan Year has commenced, a Participant may change his/her elections on a prospective basis only if the change is on account of and corresponds with a change made under the plan of the employer of the Participant's Spouse, the Participant's former Spouse, or the Participant's dependent. Any such change is permitted only if (i) the cafeteria plan of such other employer permits its participants to make only those election changes that are permitted under proposed or final IRS regulations under Code Section 125; or (ii) the period of coverage under the plan of such other employer is different than the Plan Year for this Plan. The Plan Administrator, in its sole discretion, shall decide, in accordance with prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under the plan of the employer of the Participant's Spouse, former Spouse, or dependent. The Plan Administrator may request and receive any documents it reasonably considers necessary to make such a determination.

(d) *Loss of Coverage Under Other Group Health Coverage.* After the Plan Year has commenced, a Participant may change his/her elections on a prospective basis only to add coverage for the Participant or the Participant's Spouse or dependent if the Participant or the Participant's Spouse or dependent loses coverage under any group health coverage sponsored by a governmental or educational institution. For purposes of this provision, this includes the following: (i) A state's children's health insurance program (SCHIP) under Title XXI of the Social Security Act; (ii) a medical care program of an Indian Tribal government or a tribal organization; (iii) a state health benefits risk pool; or (iv) a foreign government group health plan.

Section 5.10 Election Change Due to FMLA Leave. A Participant who is taking leave under the FMLA may revoke an existing election of accident or health plan coverage and may make such other election for the remaining portion of coverage as may be permitted under Section 3.03 of this Plan. Additionally, such a Participant may also be permitted to change his/her elections under Section 5.06(a)(iii), provided the requirements of that section are satisfied.

Section 5.11 [Reserved]

Section 5.12 Election Change Due to Issuance of a Judgment, Decree, or Order. If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) requires accident or health coverage to be provided for a Participant's dependent child, including a foster child who is a dependent of the Participant, a Participant may (a) change his/her election to provide coverage for the dependent child, provided that the Order requires the Participant to provide such coverage; or (b) change his/her election to revoke coverage for the dependent child if the Order requires that another individual, including the Participant's Spouse or former Spouse, provide coverage under that individual's plan for the dependent child and such coverage is, in fact, provided.

Section 5.13 Election Change Due to Medicare/Medicaid Entitlement. If a Participant, a Participant's Spouse, or a Participant's dependent who is entitled to receive benefits under a Group Health Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits of Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may reduce his/her election to reflect the reduction or cancellation of the coverage provided to such person under the Group Health Plan. Additionally, if a Participant, a Participant's Spouse, or a Participant's dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may increase his/her election to reflect the increased cost of providing coverage under the Group Health Plan. Any change made under this Section shall take effect on a prospective basis only. The Plan Administrator may request and receive any documents it reasonably considers necessary to make such a determination. The right to drop or add coverage under a Group Health Plan is governed by and subject to the terms of the Group Health Plan. This Section does not apply to a Health FSA.

Section 5.14 Election Change Due to Significant Change in Cost.

(a) *Increase in Participant's Share of the Cost.* If the Participant's share of the premium for coverage under a Benefit Package Option (other than a Health FSA) increases by a significant amount during a Plan Year, the Participant may either increase his/her election by a corresponding amount on a prospective basis or the Participant may revoke his/her election and, in lieu thereof, receive coverage under another Benefit Package Option (if any) providing similar coverage. If similar coverage is not available under another Benefit Package Option, the Participant may revoke his/her election without electing coverage under another Benefit Package Option.

(b) *Decrease in Participant's Share of the Cost.* If the Participant's share of the premium for coverage under a Benefit Package Option (other than a Health FSA) decreases by a significant amount during a Plan Year, the Participant may decrease his/her election by a corresponding amount on a prospective basis or, if the Participant is not currently enrolled in the Benefit Package Option, the Participant may elect to become covered under that Benefit Package Option.

(c) *Other Provisions.* The Plan Administrator, in its sole discretion, shall decide, in accordance with prevailing IRS guidance, whether a change in cost is significant and what constitutes "similar coverage" based upon all of the surrounding facts and circumstances.

(d) *Special Provisions Applicable to DCAPs.* This Section does not apply to a DCAP unless the change in cost is imposed by a dependent care provider who is not related (as that term is used in IRS regulations) to the Participant.

Section 5.15 Election Change Required by the Plan Administrator. The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount by which they have elected to reduce their Compensation for a Plan Year if the Plan Administrator determines such action is necessary or advisable to (a) satisfy any Code nondiscrimination requirements applicable to this Plan or any Pre-Tax Benefit; (b) prevent any

Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits from any Pre-Tax Benefit than would otherwise be recognized; or (c) maintain the qualified status of benefits received under this Plan. In the event contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the amount by which each affected Participant has elected to reduce his/her Compensation, beginning with the Participant in the class who had elected to reduce his/her Compensation by the highest amount, continuing with the Participant in the class who had elected the next highest amount, and so forth, until the defect is corrected.

Section 5.16 Automatic Election Change for Insignificant Changes in Cost. If the Participant's share of the premium or cost for the benefits provided under a Pre-Tax Benefit increases or decreases during the Plan Year by an insignificant amount, the Participant's election shall be increased or decreased on a prospective basis by the amount of such increase or decrease. The Plan Administrator, on a reasonable and consistent basis, shall automatically effectuate this prospective increase or decrease in the elective contributions of the affected Participants in accordance with such cost changes. The Plan Administrator, in its sole discretion, shall decide whether increases or decreases in cost are "insignificant" based upon all of the surrounding facts and circumstances, including, but not limited to, the dollar amount and/or the percentage amount of the change.

Section 5.17 Requesting and Approving Election Changes. A Participant desiring to make a change in his/her elections pursuant to this Article V must complete and submit a status change form and/or such other forms as the Plan Administrator may require. If an election change is to take effect during a Plan Year, the Plan Administrator may require the Participant to provide such proof as it reasonably considers necessary of the events underlying the request for an election change, including, but not limited to, a marriage certificate, divorce decree, birth certificate, confirming letter from the Spouse's current or former employer, or any other relevant documents. All such requests for an election change must be reviewed and approved by the Plan Administrator before the election change is given effect. All such requests must be submitted within thirty (30) days after the date giving rise to the request for an election change, except as provided in Section 5.07(c) with regard to certain HIPAA special enrollment rights that allow such requests to be submitted within sixty (60) days after the date giving rise to the request for an election change.

Section 5.18 Effective Date of Election Changes. Except as specifically provided in this Section, an election change made during the middle of a Plan Year will be given prospective effect only and will take effect as of the first administratively practicable date following the date on which the Plan Administrator approves the new elections that are being made.

(a) *Special Rule for Newly Adopted Dependent Children and Newborns.* Notwithstanding the general rule stated in this Section, and subject to the provisions of the underlying Group Health Plan, an election to increase the amount by which the Participant's Compensation is reduced in order to fund the increased cost of providing benefits under a Group Health Plan to a newly adopted dependent child or newborn may be given retroactive effect to the date of birth or date of adoption.

Section 5.19 Special Rule for Health FSAs. If an election change is permitted under the provisions of this Article V, a Participant may change his/her election as follows:

(a) A Participant may begin to participate in the Health FSA for the balance of the Plan Year; or

(b) A Participant may increase his/her election amount as long as the election does not exceed the maximum election amount permitted under the Plan; or

(c) A Participant may decrease the election amount, provided, however, that the amount elected may not be less than the amount Participant has already been reimbursed.

Section 5.20 [Reserved]

Section 5.21 Elections of Former Participants Rehired Within Thirty (30) Days of Termination. If a former Participant is rehired within thirty (30) days after the date on which the Participant's employment relationship with the Employer was terminated, the Participant will be reinstated with the same elections the Participant had before termination unless (a) the Participant would be permitted to make an election change under Article V for a reason other than a change in his/her employment with the Employer or (b) the Plan Year ended on or after the date on which the employment relationship was terminated but before the date of reinstatement.

Section 5.22 Maximum Benefits. The maximum benefits under this Plan are the maximum benefits specified in the Pre-Tax Benefits, After-Tax Benefits, and Employer-Paid Benefits.

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ARTICLE VI
PLAN ADMINISTRATION

Section 6.01 Plan Administrator. The administration of this Plan shall be under the supervision of the Plan Administrator. The Plan Administrator shall have the responsibility of ensuring that this Plan is carried out, in accordance with its terms, for the exclusive benefit of the persons entitled to participate in this Plan.

Section 6.02 Powers of the Plan Administrator. The Plan Administrator shall have such powers and duties as it considers necessary or appropriate to discharge its duties under this Plan. The powers of the Plan Administrator shall include, but are not limited to, the following:

(a) Establish rules and procedures for the purpose of administration of this Plan;

(b) Require each Participant to supply such information and sign such documents as may be necessary to administer this Plan. In the case of Participant elections, election changes, and other information supplied by the Participant, this power includes requiring elections, election changes, and other information to be submitted using electronic media, subject to and to the extent permitted under applicable IRS and Department of Labor ("DOL") regulations;

(c) Communicate with Participants through electronic media, subject to and to the extent permitted under applicable IRS and DOL regulations;

(d) Interpret, construe, and carry out the provisions of this Plan, and render decisions on the administration of this Plan, including factual and legal determinations as to whether any individual is eligible to be enrolled in and/or receive any benefit under the terms of this Plan; and

(e) Appoint such agents, attorneys, accountants, consultants, Claims Administrators, and any other persons as may be needed for proper administration of this Plan.

In exercising these powers, the Plan Administrator shall act in its sole discretion, giving due regard for the reason and purpose for which this Plan is established and maintained. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

The Plan Administrator shall have no power to waive, alter, or fail to apply the terms of this Plan.

Section 6.03 Plan Must Be Nondiscriminatory. The Plan Administrator shall administer this Plan in a nondiscriminatory manner so all persons similarly situated will receive substantially similar treatment.

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ARTICLE VII
HIPAA MEDICAL PRIVACY
FOR THE USD #262 VALLEY CENTER MEDICAL PLAN, USD #262 VALLEY CENTER DENTAL PLAN, AND USD #262 VALLEY CENTER HEALTH FLEXIBLE SPENDING ACCOUNT

PART I
PREAMBLE

Section 7.01 Purpose and Effective Date. This HIPAA Medical Privacy Article is adopted in response to the provisions of the Medical Privacy Regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Section 7.02 Application of Article VII. The USD #262 Valley Center Welfare Benefit Plan is a "hybrid entity." As such, the Plan has made a separate hybrid entity designation to define the medical components from the non-medical components of the Plan.

This Article shall *only* apply to the USD #262 Valley Center Medical Plan, USD #262 Valley Center Dental Plan, and USD #262 Valley Center Health Flexible Spending Account (hereafter referred to as the "Group Health Plan").

All other benefits provided by the Employer through the USD #262 Valley Center Welfare Benefit Plan are either (a) not "group health plans" as defined by HIPAA or (b) provided solely through an insurance contract with a health insurance issuer or HMO and do not create or receive protected health information (PHI) other than "summary health information" as defined in 45 C.F.R. Section 164.504(a) or enrollment and disenrollment information.

The Article shall supersede the provisions of the Group Health Plan to the extent those provisions are inconsistent with the provisions of this Article.

PART II
DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE EMPLOYER

Section 7.03 Prohibition Against Disclosing Protected Health Information to the Employer. Except as permitted by this Part II, the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may not disclose PHI to the Employer.

Section 7.04 Definitions. For purposes of this Part II, the following definitions shall apply. These definitions are based on and shall be construed and applied in a manner that is consistent with the definitions set forth in Part 160 and Part 164 of Title 45 of the Code of Federal Regulations.

(a) "*Breach*" means the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such PHI. The following three (3) types of unauthorized acquisition, access, use, or disclosure are excluded from the definition of a "breach:"

(i) Any unintentional acquisition, access, or use of PHI by an Employee or individual acting under the authority of the Group Health Plan if such acquisition, access, or use was made in good faith and within the course and scope of employment or other professional relationship of such Employee or individual, respectively, with the Group Health Plan, and the information is not further acquired, accessed, used, or disclosed by any person in a manner not permitted by the HIPAA Medical Privacy or Security Rules;

(ii) Any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by the Group Health Plan to another similarly situated individual at the same facility so long as the information received is not further used or disclosed in a manner not permitted by the HIPAA Medical Privacy or Security Rules; and

(iii) Any disclosure to an unauthorized person where the PHI that was disclosed would not reasonably have been retained by such person.

(b) "*De-identified Health Information*" means health information that does not identify an individual and for which there is no reasonable basis for believing that the information may be identified with a specific individual. Health information will be considered to be De-identified Health Information if the information listed in Section 164.514(b)(2)(ii) of Title 45 of the Code of Federal Regulations has been removed. Information that must be removed, pursuant to this Section of the regulations, includes (but is not limited to) names, geographical locations more specific than the first three (3) digits of a ZIP code, dates (except for the year of birth), telephone and fax numbers, and Social Security numbers.

(c) "*Electronic Media*" means:

(i) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical tape, or digital memory card; or

(ii) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the Internet, extranet (using Internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including paper, facsimile, and voice via telephone are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

(d) "*Electronic Protected Health Information" ("e-PHI")* is PHI that is transmitted or maintained in electronic media.

(e) "*Individually Identifiable Health Information"* means information for which each of the following conditions is met:

(i) The information is created or received by a health care provider, a health plan (including a group health plan or a health insurance issuer), an employer, or a health care clearinghouse;

(ii) The information relates to the past, present, or future physical or mental health 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

(iii) The information either identifies the individual or provides a reasonable basis for believing that the information can be used to identify the individual.

(f) "*Plan Administration Functions"* means administrative functions performed by the Employer on behalf of the Group Health Plan. Plan Administration Functions do not include any functions performed by the Employer in connection with any other benefit or benefit plan.

(g) "*Protected Health Information (PHI)"* means Individually Identifiable Health Information except that PHI does not include employment records held by a covered entity in its role as an employer, educational records covered by the Family Educational Rights and Privacy Act, or health care records of post-secondary degree students.

(h) "*Security Incident"* (as defined in 45 C.F.R. 164,304) means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(i) "*Security Rule"* shall mean the Security Standards and Implementation Specifications in 45 C.F.R. Part 160 and Part 164, subpart C.

(j) "*Summary Health Information"* means information that summarizes the claims history, claims expenses, and/or types of claims experienced by individuals for whom the Employer has provided medical coverage under the Group Health Plan and from which the identifying information listed in Section 164.514(b)(2)(ii) of Title 45 of the Code of Federal Regulations has been removed, except that geographical locations may be described using a five (5) digit ZIP code.

(k) "*Unsecured PHI"* means PHI that is not secured through the use of a technology or methodology specified by the Secretary of Health and Human Services through guidance issued by the Secretary.

Section 7.05 Enrollment and Disenrollment Information. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose information to the Employer as to whether a given individual is enrolled in, or has been disenrolled in, the medical coverage provided under the Group Health Plan.

Section 7.06 Plan Administration Functions. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose PHI or e-PHI to the Employer if the Employer requires such information in order to carry out its responsibilities in connection with the administration of the Group Health Plan. Such responsibilities may include the following:

(a) Reviewing the performance of the Group Health Plan, including the performance of any insurance companies providing group health coverage for the Group Health Plan and the performance of any business associates of the Group Health Plan;

(b) Overseeing the adjudication of benefit claims, including the responsibility to provide coverage upon the initial submission of claims and the disposition of any Appeals that are filed with respect to claims that are denied in whole or in part;

(c) Overseeing the coordination of benefits and pursuing and/or responding to claims for subrogation;

(d) Conducting cost management and planning-related analysis, including the forecasting of expected health care costs based on current utilization of benefits;

(e) Detecting fraud or abuse;

(f) Determining whether charges for services are appropriate or justified;

(g) Requesting underwriting or premium rating and other activities related to the creation, renewal, or replacement of a contract of health insurance;

(h) Securing, placing, and/or receiving payments pursuant to a policy of stop-loss or excess loss insurance in the event the Group Health Plan is self-insured in whole or in part;

(i) Ensuring that the required premiums for the coverage provided under the Group Health Plan are obtained from the persons obligated to pay the same and remitting such premiums to the appropriate insurance carriers and/or third party service providers as may be necessary or appropriate;

(j) Providing assistance, upon request, to Participants and their covered dependents in addressing and resolving problems that they may encounter with the approval and payment of claims that have been submitted on their behalf;

(k) Reporting corporate finances with respect to current and projected health care costs;

(l) Providing information that is legally required in response to a court order, subpoena, discovery, or other process or to the Department of Health and Human Services ("HHS") in connection with its enforcement activities, but only to the extent that the Employer is required to act on behalf of the Group Health Plan in providing such information and only if the Group Health Plan is permitted to make the disclosure under the provisions of the HIPAA Medical Privacy Regulations; and

(m) Performing other functions as required to effectively offer benefits under the Group Health Plan.

The use and disclosure of PHI or e-PHI pursuant to this Section 7.06 is subject to the provisions of Section 7.07.

Section 7.07 Conditions for Disclosure for Plan Administration Functions. With respect to any PHI or e-PHI that is disclosed to the Employer by the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan pursuant to Section 7.06, the Employer agrees to do the following:

(a) Not use or further disclose PHI or e-PHI other than as permitted or required by the Group Health Plan document or as required by law;

(b) Ensure that any agents or subcontractors to whom the Employer provides PHI or e-PHI received from the Group Health Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI or e-PHI;

(c) Not to use or disclose PHI or e-PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plans of the Employer;

(d) Report to the Group Health Plan any use or disclosure of PHI or e-PHI that is inconsistent with the uses or disclosures permitted by this Group Health Plan to the extent it becomes aware of such information. If and as required by any applicable HHS regulations, this reporting requirement will also include reporting to the Group Health Plan any Breach of Unsecured PHI that it discovers, so that the affected individual(s), the media (if applicable), and HHS may be appropriately notified of the Breach as required by the regulations issued regarding breach notifications;

(e) Effective February 17, 2010, restrict the disclosure of PHI of an individual (unless the disclosure is otherwise required by law) where the disclosure is to the Group Health Plan for purposes of carrying out payment or health care operations (and not treatment) and the PHI pertains to a health care item or service for which the health care provider has been paid out-of-pocket in full;

(f) Make the PHI or e-PHI that it receives from the Group Health Plan and/or health insurance issuer available to the individual to whom it relates in accordance with the individual's right to access his/her own information as that right is set forth in Section 164.524 of Title 45 of the Code of Federal Regulations;

(g) Make PHI or e-PHI available for amendment and to incorporate any requested amendments in accordance with and to the extent required by Section 164.526 of Title 45 of the Code of Federal Regulations;

(h) Make available the information that is required to provide an accounting to an individual of the disclosures that have been made of the individual's PHI or e-PHI in accordance with and to the extent required by Section 164.528 of Title 45 of the Code of Federal Regulations;

(i) Make its internal practices, books, and records relating to the use and disclosure of PHI or e-PHI available to the Secretary of Health and Human Services for purposes of allowing the Secretary to determine compliance by the Group Health Plan with HIPAA's medical privacy and security requirements;

(j) If feasible, return or destroy all PHI or e-PHI received from the Group Health Plan or a health insurance issuer when such information is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer may limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

(k) Ensure that adequate separation between the Employer and the Group Health Plan exists, as set forth in more detail in Part III;

(l) Provide a certification to the Group Health Plan as required by Section 7.08; and

(m) If the Employer creates, receives, maintains, or transmits any e-PHI (other than enrollment and disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Group Health Plan, it will do the following:

(i) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI;

(ii) Ensure that any agent (including subcontractors) to whom it provides such e-PHI agree to implement reasonable and appropriate security measures to protect the information; and

(iii) Report to the Group Health Plan any Security Incident of which it becomes aware.

Section 7.08 Certification by the Employer. In the absence of an authorization, the Group Health Plan may not disclose any PHI or e-PHI to the Employer unless and until the Group Health Plan is in receipt of a certification from the Employer. The Employer must certify in the certification that the Group Health Plan has been amended to incorporate the provisions required by Section 164.504(f)(2)(ii) of Title 45 of the Code of Federal Regulations. The Employer must further certify in the certification that the Employer agrees to the conditions of disclosure as set forth in Section 7.07 and in Part III.

PART III
ADMINISTRATIVE SAFEGUARDS

Section 7.09 Adequate Separation Between the Employer and the Plan. No person employed by the Employer may receive or have access to PHI or e-PHI from the Group Health Plan except as set forth in this Part III. The Employer will ensure that the provisions of this Part are supported by reasonable and appropriate security measures to the extent that the "authorized employees" have access to e-PHI. Further, this Part III does not apply to information that is not considered to be PHI or e-PHI, such as Summary Health Information and De-identified Health Information, or to information that the Employer receives in a way that is separate and independent from this Group Health Plan.

Section 7.10 Authorized Employees. The following Employees ("Authorized Employees") are permitted to use and have access to PHI or e-PHI to the extent necessary to perform the plan administration functions, as set forth in Part II above, that the Employer performs for the Group Health Plan in order to provide benefits to Participants:

Superintendent
Director of Finance

In the case of an unanticipated or unusual event, for a limited time and purpose only, Employees designated in writing by the Privacy Officer at the time of such event to resolve the unanticipated or unusual event may have access to PHI or e-PHI. For example, an employee in the IT department may need access, but only for the limited purpose of accessing a database containing PHI or e-PHI to correct a computer virus or similar problem, hardware defect, or other system issue. Similarly, in-house counsel of the Employer (if applicable), including counsel's support staff, may need access to PHI or e-PHI, but only for the limited purpose of assisting in the investigation of and otherwise responding to complaints alleging violations of the policies and procedures established by the Employer.

Such Employees accessing PHI or e-PHI due to an unanticipated or unusual event may be identified by names, job title, or any other designation that adequately identifies the Employees. In addition, the Employees shall receive proper training regarding the HIPAA medical privacy and security rules and shall comply fully with the Plan's policy and procedures. Any such appointment shall be documented and available for inspection and copying.

Section 7.11 Use Pursuant to an Authorization. Employees of the Employer may use and have access to PHI or e-PHI to the extent authorized by a valid authorization for the purposes set forth in the authorization.

Section 7.12 Consequences of Unauthorized Use of PHI or e-PHI. If it is determined that an Employee has obtained, used, or disclosed PHI or e-PHI in a manner or way that is not permitted by this Part III, the Employee will be subject to discipline by the Employer in accordance with policies and procedures established by the Employer.

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ARTICLE VIII
GROUP HEALTH PLAN CONTINUATION COVERAGE

This Article VIII applies only to Group Health Plans as that term is defined in Section 2.17. With respect to the Health FSA, however, the specific terms and conditions of continuation coverage as described in this Article are modified by Appendix C, Article C-IV.

Section 8.01 Continuation of Coverage under COBRA. If a "qualified beneficiary" loses (or would lose) coverage under this Plan as a result of a "qualifying event," the Plan Administrator will give that qualified beneficiary the opportunity to continue coverage by returning a COBRA election form and by paying the applicable premium. The qualified beneficiary's right to continue coverage under this Plan is subject to the following:

(a) *Qualified Beneficiary.* For purposes of this Section, a "qualified beneficiary" means the Participant, the Participant's Spouse, and the Participant's dependents, but only if such persons were covered under this Plan on the day before the "qualifying event." The term "qualified beneficiary" shall also include any children who are born to or adopted by the Participant while the Participant is continuing his/her coverage under COBRA.

(b) *Qualifying Event.* For purposes of this Section, a "qualifying event" means one (1) of the following if the qualified beneficiary would otherwise lose his/her eligibility for coverage under this Plan as a result of such an event:

(i) Termination of the Participant's employment (other than for "gross misconduct") or a reduction in the number of hours the Participant normally works.

(ii) Death of the Participant.

(iii) Divorce or legal separation of the Participant and the Participant's covered Spouse.

(iv) The Participant's entitlement to Medicare.

(v) A covered dependent no longer satisfies the conditions for being covered as a dependent of the Participant.

(vi) The Employer files a Chapter 11 bankruptcy (but only as to coverage that is being provided to a retired Participant and his/her Spouse and covered dependents *and* only if the Employer is terminating this Plan while continuing to offer group health coverage to some other group of Employees).

(c) *Election to Continue Coverage.* Any election to continue coverage that would otherwise be lost as a result of a qualifying event must be made within the time frame established by the COBRA statute and must be made in accordance with such reasonable procedures as the Plan Administrator may establish.

(d) *Premium for COBRA Continuation Coverage.* A qualified beneficiary who elects to continue coverage must pay the entire cost for such coverage along with an additional two percent (2%) charge or, with respect to an extension of the maximum coverage period due to a subsequent disability, an additional fifty percent (50%) charge. Premiums must be paid on a timely basis in accordance with such reasonable procedures as the Plan Administrator may establish.

(e) *Maximum Coverage Period.* The maximum period of time for which COBRA continuation coverage will be provided shall be as follows:

(i) *Termination of Employment or Reduction in Hours.* Eighteen (18) months if coverage is lost as a result of termination of the Participant's employment or a reduction in the Participant's hours.

(ii) *Disability Extension.* Twenty-nine (29) months if a qualified beneficiary is determined by the Social Security Administration to have been disabled at any time during the first sixty (60) days of COBRA coverage and the qualified beneficiary notifies the Plan Administrator of such determination while COBRA continuation coverage is still in effect and in accordance with such reasonable procedures as the Plan Administrator may establish.

(iii) *Employer Bankruptcy.* The lifetime of the Participant *if:*

(A) The Employer is providing coverage after the Participant has retired;

(B) The Employer files a Chapter 11 bankruptcy;

(C) The Employer terminates this Plan (or substantially eliminates coverage under this Plan with respect to a qualified beneficiary within a one-year period before or after such bankruptcy proceeding was filed); and

(D) The Employer continues to maintain a group health plan for any other group of employees.

In such an event, the surviving Spouse and surviving covered dependents of the Participant shall further be entitled to elect COBRA continuation coverage for an additional thirty-six (36) months following the death of Participant.

(iv) *Second Qualifying Event.* Thirty-six (36) months if a second qualifying event takes place while coverage is being continued following the original qualifying event and the second qualifying event is other than the termination of the Participant's employment or a reduction in the Participant's hours.

(v) *Any Other Qualifying Event.* Thirty-six (36) months for any qualifying event for which a shorter maximum coverage period is not set forth in this Subsection (e).

(f) *Termination of COBRA Continuation Coverage.* COBRA continuation coverage may be terminated prior to the expiration of the maximum coverage period if any one (1) of the following events occurs:

(i) A qualified beneficiary becomes covered under another group health plan;

(ii) A required premium is not paid within the applicable deadline (including any applicable grace period);

(iii) The Employer terminates this Plan and no longer offers coverage under a group health plan to any of its Employees;

(iv) After electing COBRA coverage, a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both);

(v) During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled; or

(vi) Coverage would have been terminated under the same circumstances for a Participant or beneficiary not receiving continuation coverage (e.g., a Participant or beneficiary engages in fraudulent activities against the Plan).

(g) *Coverage Provided During COBRA Continuation Period.* The coverage provided during the COBRA continuation period shall be identical to the coverage provided to similarly situated persons covered under the Plan with respect to whom a qualifying event has not occurred. If coverage under the Plan is modified for any group of similarly situated persons, the coverage shall also be modified in the same manner for all qualified beneficiaries who have elected to continue their coverage under COBRA.

(h) *Calculation of COBRA Deadlines.* The maximum coverage period shall begin as of the date on which the qualified beneficiary would otherwise lose coverage as a result of the original qualifying event (as opposed to beginning on the date of the qualifying event itself). The deadline for the Employer to notify the Plan Administrator of a qualifying event (if applicable) and the deadline for a qualified beneficiary to notify the Plan of a qualifying event (if applicable) shall also be measured from the date that coverage is lost.

(i) *Construction and Application.* This Section shall be construed and applied in a way that is consistent with the requirements of the COBRA statute and COBRA regulations issued by the IRS and the DOL.

(j) *Employers Not Required to Offer COBRA Continuation Coverage.* This Section shall not apply to the Employer if the Employer is not required by law to offer COBRA continuation coverage. The Employer, for example, will not be not required to offer COBRA continuation coverage if the Employer qualified for the "small employer" exception to COBRA based on the number of employees that it employed during the previous calendar year. Generally, if this number is less than twenty (20), then the Employer is not subject to COBRA. In the event, however, that the Employer has twenty (20) or more employees as determined under COBRA (considering "controlled group" rules and special rules for part-time employees), this Article will apply as described above.

Section 8.02 USERRA Continuation Rights. A Participant who is absent from employment as a result of military service shall have the right to elect continuation coverage for a period of up to twenty-four (24) months. The Participant's right to continue coverage is subject to the following:

(a) *Payment of Premium.* The Participant must pay the applicable premium for any USERRA continuation coverage. For a leave of absence for less than thirty-one (31) days, the Participant may not be required to pay more than the Participant would have paid had the Participant not been on leave. For a leave of absence of more than thirty (30) days, Participant must pay the entire cost of coverage plus an additional two percent (2%).

(b) *Failure to Apply for Reemployment.* Following completion of the Participant's military service, the Participant's right to continue coverage under USERRA shall end if the Participant does not apply for reemployment within the applicable time period set forth in USERRA (43 U.S.C. § 4312(c)).

(c) *Reasonable Procedures.* The Plan Administrator shall have the authority to adopt such reasonable procedures as the Plan Administrator may consider necessary or advisable in order to implement the provisions of this Section.

(d) *Construction and Application.* This Section shall be construed and applied in a way that is consistent with the requirements of the USERRA statute and any applicable regulations that may be issued by the DOL.

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ARTICLE IX
GROUP HEALTH PLAN CLAIMS PROCEDURES
(Does Not Apply to the Health FSA)

Section 9.01 Where to File Claims. Any Claim for benefits which arises under a Group Health Plan shall be filed with the Claims Administrator.

Section 9.02 Persons Who May File Claims. Claims may be filed by the Claimant or by the Claimant's duly authorized representative.

(a) Prior to recognizing any such appointment of an authorized representative, the Claims Administrator may require proof that the representative has been duly appointed.

(b) Notwithstanding the foregoing rule, a health care professional with knowledge of the Claimant's medical condition shall be permitted to act as the authorized representative of the Claimant with respect to Urgent Care Claims.

(c) For purposes of these claims procedures, the deadlines applicable to a Claimant shall apply to his/her authorized representative in the event he/she elects to use an authorized representative in filing any Claim or Appeal.

Section 9.03 Claims Procedures for Fully-Insured Group Health Plans. Claims made for benefits, and any Appeals from the denial of such Claims, under the fully-insured Group Health Plans, shall be processed in accordance with the claims procedures of the insurer, which are set forth in the Certificate of Coverage. Unless stated otherwise in the policy of insurance, prior to initiating legal action concerning a Claim in any court, state or federal, against this Plan, any trust used in conjunction with this Plan, the Employer, the Claims Administrator, and/or the Plan Administrator, a Claimant must first exhaust the internal administrative remedies provided by the insurer. Failure to exhaust the internal administrative remedies provided by the insurer shall be a bar to any civil action concerning a Claim for benefits under this Plan. Once a Claimant has exhausted his/her administrative remedies, he/she may file a lawsuit challenging the denial of the Claim. Such lawsuit must be commenced no later than one hundred eighty (180) days after the Plan issues a final adverse benefit determination or, if external review is sought by the Claimant, no later than one hundred eighty (180) days after the Claim is denied in whole or in part on external review.

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ARTICLE X
TERMINATION AND AMENDMENT OF THE PLAN

Section 10.01 Termination and Amendment. The Employer may amend or terminate this Plan at any time by written instrument duly adopted by the Employer.

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ARTICLE XI
MISCELLANEOUS

Section 11.01 Construction. Words used in the masculine also apply to the feminine and words used in the feminine also apply to the masculine. Wherever the context dictates, the plural includes the singular and the singular includes the plural.

Section 11.02 Employment Not Guaranteed. Nothing contained in this Plan or in any other plan which is a part of the Plan, or any modification or amendment to this Plan, or in the creation of any account, or the payment of any benefit, gives any Employee, Participant, or beneficiary any right to continue employment, any legal or equitable right against the Employer, its Employees or agents, or against the Plan Administrator, except as expressly provided by this Plan.

Section 11.03 Funding and Expenses. All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Any amounts that may be payable under any of the Pre-Tax Plans, After-Tax Plans, and the Employer-Paid Plans shall be paid in accordance with the provisions of the plan document for such plans. All administrative costs of this Plan shall be borne by the Employer.

Section 11.04 Indemnification. To the extent permitted by law, the Employer shall indemnify and hold harmless any Employee to whom fiduciary responsibility with respect to this Plan is allocated or delegated, from and against any and all liabilities, costs, and expenses incurred by any such Employee as a result of any act, or omission to act, in connection with the performance of duties, responsibilities, and obligations under this Plan, other than such liabilities, costs, and expenses as may result from the gross negligence or willful misconduct of any such person.

Section 11.05 Information. The Plan Administrator may require each Participant to supply such information and sign such documents as may be necessary to implement this Plan.

Section 11.06 Limitation on Liability. A Plan fiduciary shall be entitled to rely upon information from any source assumed in good faith to be correct. No person shall be subject to any liability with respect to duties under this Plan unless that person acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated.

Section 11.07 Named Fiduciary. The named fiduciary of this Plan shall be the Employer. The Employer shall have complete authority to control and manage the operation and administration of this Plan.

Section 11.08 Negative Paychecks. The Employer shall have the power to adopt rules and procedures addressing the sequence in which amounts shall be deducted or withheld from the compensation payable from the Employer to a Participant in the event that such compensation is less than the combined total of the following:

(a) Taxes required to be withheld from the Participant's compensation;

(b) The amounts the Participant has elected to defer into a plan maintained by the Employer;

(c) The salary reductions elected by the Participant under this Plan or under any similar plan maintained by the Employer; and

(d) Such other amounts that the Employer may be required to withhold or deduct from the Participant's compensation.

If no such rules or procedures have been adopted, the Employer shall deduct amounts required to be withheld for taxes and amounts necessary to pay for the Participant's medical coverage prior to deducting any other amounts.

Section 11.09 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant.

Section 11.10 Nonassignability. The right of any Participant to receive any benefits under this Plan is not subject to alienation or assignment and is not subject to the claims of the creditors of the Participant except to the extent provided by law.

Section 11.11 Prohibition Against Retroactive Entry into the Plan. In the event that a person was determined to be ineligible to participate in the Plan due to the person's classification as an independent contractor and such classification is later determined by a court or administrative agency to have been incorrect, the person shall be eligible to enter the Plan on a prospective basis only. Except as may be required in connection with HIPAA special enrollment rights, no person shall be allowed to enter the Plan on a retroactive basis.

Section 11.12 Reimbursement of Payments Made in Error. The Plan shall have the right to reimbursement from any Participant, covered dependent, or assignee for any benefit overpayments attributable to mistake, clerical error, fraud, or any other reason contributing to benefit payments to which the Participant, covered dependent, or assignee was not entitled.

Section 11.13 Return of Premiums. If money is returned in any form by an insurance company that provided or is providing benefits under this Plan, including, but not limited to, a rebate of premiums previously paid or proceeds from demutualization, or rebates resulting from an insufficient "medical loss ratio" (MLR), the Plan Administrator shall have the discretion to apply such amounts to the payment of Plan expenses, the reduction of premiums, and/or benefit enhancements. The Plan Administrator shall further have the discretion to allocate such funds in any manner deemed appropriate.

Section 11.14 Rights to Employer's Assets. No Participant or beneficiary has any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under this Plan, and then only to the extent that the benefits payable under the component benefit plans are payable solely from the assets of the Employer.

Section 11.15 State Law. The laws of the state of Kansas will determine all questions arising with respect to the provisions of this Plan except to the extent superseded by federal law.

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IN WITNESS WHEREOF, the Employer adopts this amended and restated Plan effective the 1st day of April, 2015.

USD #262 VALLEY CENTER

By:_____
Cory Gibson, Superintendent

CERTIFICATION BY THE EMPLOYER TO THE PLAN

I hereby certify on behalf of the Employer that the Plan has been amended to incorporate the provisions required by 45 C.F.R. § 164.504(f)(2)(ii). Such provisions are only applicable to Group Health Plans within the Plan.

I further certify on behalf of the Employer that the Employer agrees to comply with the provisions of the Plan, as amended, governing the use and disclosure of PHI or e-PHI by the Plan to the Employer. This Certification is made pursuant to 45 C.F.R. § 164.504(f)(2)(ii).

USD #262 VALLEY CENTER

By:_____ Date: _____

APPENDIX A
MEDICAL PLAN

This Appendix A contains the terms and conditions specific to the USD #262 Valley Center Medical Plan that may be elected under Section 4.01 of the Plan. Unless otherwise altered by the terms of this Appendix A, the terms and conditions of the Plan are incorporated into, and made applicable to, this Medical Plan.

Section A1.01 Eligibility/Plan Entry Dates. The eligibility conditions and the Medical Plan entry dates are the same as those for the Plan.

Section A1.02 Medical Benefits. Benefits under this Plan are identical to those described in, and shall be paid pursuant to the terms of, the Group Contract ("Blue Cross Blue Shield of Kansas Group Contract") between Blue Cross Blue Shield of Kansas ("BCBS") and the Employer (Group No. 09327). The provisions of that contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by BCBS. The Employer makes no promise and shall have no obligation to provide or pay such benefits from its own assets. The rights and conditions with respect to the benefits payable under this Medical Plan shall be determined from the BCBS Group Contract. The Participant shall bear fully any and all risk of BCBS's insolvency.

Section A1.03 Cost of Coverage. The Participant's monthly premiums are determined pursuant to the BCBS Group Contract. Under the terms of the Group Contract, BCBS may change the premiums from time to time. The Participant must pay the cost of the monthly premium for coverage on a pre-tax basis. The Employer will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant. If money is returned in any form by BCBS, including but not limited to a rebate or proceeds from demutualization, the Plan Administrator shall apply such amounts to the payment of Plan expenses and/or the reduction of premiums.

Section A1.04 Election to Participate. A Participant who desires to receive medical insurance coverage under this Medical Plan must elect to participate in this Medical Plan and must make arrangements to pay his/her share of the applicable premium. If a Participant does not elect to receive medical coverage under this Medical Plan, the Employer will not provide him/her with any medical coverage.

Section A1.05 Payment of Premium. A Participant who has elected to participate in this Medical Plan may pay the applicable premium on a pre-tax basis by entering into a salary reduction agreement pursuant to the terms and provisions of the Plan. Except for those Participants who are (a) exercising their right to continuation coverage pursuant to Section A1.06 below, (b) exercising their right to continue coverage during a qualifying unpaid leave pursuant to Section 3.03, or (c) eligible pursuant to Section 2.12(b), all premiums must be paid through pre-tax salary reductions.

Section A1.06 Continuation of Coverage. An individual who will lose coverage under this Medical Plan may have the right to continue coverage under this Medical Plan as described in Article VIII.

Section A1.07 Children Subject to a NMSN. Children who are the subject of a National Medical Support Notice ("NMSN") shall become "alternate recipients" of benefits under this Medical Plan in accordance with such order. The Plan Administrator shall establish reasonable procedures to determine the qualified status of a NMSN. Upon receiving a NMSN, the Plan Administrator shall promptly follow the instructions on such Notice.

Section A1.08 Claims Administration. BCBS will act as Claims Administrator with respect to any claim for benefits under this Medical Plan. BCBS has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the Group Contract. Except as provided by law, all decisions of the Claims Administrator shall be final and binding.

Section A1.09 Termination of Participation. A Participant ceases to be a Participant as of the earliest of the following:

(a) The last effective date of coverage – as specified by the insurance Group Contract – following the Participant's termination of employment with the Employer;

(b) The date on which the Participant's election to participate expires;

(c) The end of a period for which a required contribution by the Participant was last paid, taking into account any grace periods required by law;

(d) The last effective date of coverage – as specified by the insurance Group Contract – following the date on which the Participant ceases to be an Eligible Employee; or

(e) The date on which this Medical Plan terminates.

Notwithstanding anything in this Section to the contrary, an individual who would normally be required to terminate participation may continue to be a Participant in this Medical Plan if and to the extent such individual elects continuation of benefits under the rules in Section A1.06.

Section A1.10 Character of Benefits Provided. This Medical Plan does not provide medical treatment or advice. It merely pays for the cost of selected benefits as described in, and in accordance with, the provisions of the Group Contract. The fact that a particular medical service may not be eligible for reimbursement under this Medical Plan does not mean that a Participant or other person who is covered under this Medical Plan should not receive that service.

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GROUP: 09327

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ISSUED TO: SAMPLE 09/20/2015
GROUP ID: 09327 INSURED ID: SAMPLE

Women's Health Care and Cancer Rights Act (WHCRA) Notice

In accordance with the requirements of WHCRA and K.S.A. 40-2, 166 Blue Cross and Blue Shield of Kansas is notifying you of the following coverage mandated by state and federal law. When the need for such benefits is determined by the Insured and the Insured's attending physician, benefits include the following:

- Reconstruction of the breast on which a mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatments for physical complications of all stages of mastectomy, including lymphedemas.

Normal deductible, coinsurance, and/or copay amounts applicable to your health coverage are also applicable to these benefits.

BlueCross BlueShield of Kansas

An Independent Licensee of the
Blue Cross Blue Shield Association.

GROUP NAME: USD 262 VALLEY CENTER

GROUP NUMBER: 09327

ISSUED TO: SAMPLE

IDENTIFICATION NUMBER: SAMPLE

Form FL-793 1/14

09/18/2015

ISSUED TO: SAMPLE 09/20/2015
GROUP ID: 09327 INSURED ID: SAMPLE

09/18/2015

ISSUED TO: SAMPLE 09/20/2015
GROUP ID: 09327 INSURED ID: SAMPLE

An Independent Licensee of the
Blue Cross Blue Shield Association.

The following information is either provided to you as an insured, or is available to you upon request:

- A complete description of the health care services, items and other benefits to which you are entitled.
- A complete description of limitations, exceptions and exclusions of your health benefit plan.
  - A listing of contracting providers, their business addresses, telephone numbers, availability and any network limitations.
  - A notification in advance of any changes in the health benefit plan which either reduces coverage or benefits, or increases the cost of the plan.
  - A description of the appeal procedures available under the health benefit plan and your rights regarding termination, disenrollment, nonrenewal or cancellation of coverage.

GROUP NAME: USD 262 VALLEY CENTER

GROUP NUMBER: 09327

ISSUED TO: SAMPLE

IDENTIFICATION NUMBER: SAMPLE

Form FL-794 1/14

09/18/2015

ISSUED TO: SAMPLE 09/20/2015
GROUP ID: 09327 INSURED ID: SAMPLE

09/18/2015

ISSUED TO: SAMPLE 09/20/2015
GROUP ID: 09327 INSURED ID: SAMPLE

Privacy of financial information is of concern to all of us, and in response to these concerns, the federal government has required states to adopt laws that require insurance companies to explain their privacy practices. This federal law is commonly referred to as Gramm-Leach-Bliley and is separate from the federal law commonly referred to as HIPAA Privacy which became effective on 4/14/2003 and for which You have been sent the Notice of Privacy Practices concerning protected health information as required by that law. Our privacy practices for "non-public personal financial information" are set out below. We want to assure You that we take Your privacy concerns seriously, and join with Your lawmakers in believing this disclosure of such practices is an important idea.

OUR PRIVACY PRACTICES REGARDING FINANCIAL INFORMATION

Blue Cross and Blue Shield of Kansas has the following practices regarding nonpublic personally identifiable financial information with respect to our customers.

The nonpublic personal financial information we collect consists of information You provide in applications or enrollment forms (such as name, address, social security number, telephone number), or changes in that information You submit to us, and whether You hold other health coverage.

We collect such information from the following sources:

- Information we receive from You on applications or other forms;
- Information about Your transactions with us and our affiliate;
- Information we receive from others, if You hold duplicate coverage subject to coordination with coverages we issue or administer.

We do not disclose such information about our customers or former customers to anyone except:

- We disclose such information as permitted by law. Examples of disclosures we make which are permitted by law include disclosures of the fact of enrollment (a type of personally identifiable financial information) collected by one affiliate to the other, disclosures to persons providing services to us necessary to adjudicate claims, and disclosures to health care providers allowing such providers to determine your eligibility for coverage.
- We may disclose Your name, address and telephone number which we receive from You on Your applications or other forms to companies that perform customer satisfaction or other surveys on our behalf. Such companies have agreed not to redisclose such information to others.

We restrict access to nonpublic personal financial information about You to those employees who need to know that information to provide products or services to You. We maintain physical, electronic, and procedural safeguards to guard Your personal financial information.

Form FL-12 5/08

ISSUED TO: SAMPLE 09/20/2015
GROUP ID: 09327 INSURED ID: SAMPLE

09/18/2015

BlueCross BlueShield of Kansas

An Independent Licensee of the
Blue Cross Blue Shield Association.

COMPREHENSIVE MAJOR MEDICAL GROUP CERTIFICATE

This Certificate describes the benefits provided in a Group Contract by Blue Cross and Blue Shield of Kansas, Inc. (herein called "Blue Cross and Blue Shield of Kansas" or "the Company") Topeka, Kansas, and the exclusions and limitations. This Certificate may be canceled as described in this Certificate.

To the extent that benefits of this Certificate are part of an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act (commonly known as ERISA), Blue Cross and Blue Shield of Kansas shall have the full and exclusive authority to construe covered benefits that are stated in the Certificate.

GROUP NAME:	USD 262 VALLEY CENTER
GROUP NUMBER:	09327
ISSUED TO:	SAMPLE
IDENTIFICATION NUMBER:	SAMPLE

You have specific consumer rights regarding internal and external appeals. Our complete appeals procedure process is available in Spanish. To request a Spanish version of the appeals process, please call our Customer Service number on the back of your member identification card.

Usted tiene derechos específicos como consumidor con relación a las apelaciones internas y externas. Nuestro proceso completo para el procedimiento de apelaciones está disponible en español. Para solicitar una versión en español del proceso de apelaciones, llame a nuestro número de Servicio al cliente que se encuentra en la parte posterior de su tarjeta de identificación del afiliado.

Form FL-836 1/15

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GENERAL DEFINITIONS

A. **Accidental Injury** is an unintended injury to Your body caused through external means. "Accidental Injury" does not include: injuries that occur before the date from which You have had continuous coverage with the Company; disease or infection (except for infection that occurred from an accidental cut or wound); hernia; injuries to the teeth caused by biting or chewing.

B. **Alternate Recipient** means any child of an Insured who is recognized under a Qualified Medical Child Support Order as having a right to enrollment under this Contract.

C. **Blue Cross Company and/or Blue Shield Company** means the Company and any other corporation approved or licensed by the Blue Cross Blue Shield Association to use the registered service marks and names.

D. **Certificate** means a summary of the provisions of the Group Contract that affect Insureds. A Certificate is issued by the Company to the Contract Holder for delivery to each enrolling employee.

E. **Coinsurance** means the percentage of the allowable charge for a covered service at which payment is made after any applicable Deductible amount has been satisfied.

F. **Company** means Blue Cross and Blue Shield of Kansas.

G. **Company Service Area** means the State of Kansas except Johnson and Wyandotte Counties.

H. **Contract or Group Contract** means the Contract between the Company and the Contract Holder and includes: all of the forms issued to the Contract Holder by Blue Cross and Blue Shield of Kansas, including endorsements, amendments, and riders.

I. **Contracting Provider** means an Eligible Provider who has entered into a Contracting Provider Agreement with the Company.

J. **Convalescent Care, Custodial/Maintenance Care or Rest Cures** means treatment or services, regardless of by whom recommended or where provided, in which the service could be rendered safely and reasonably by self, family, or other caregivers who are not Eligible Providers. The purpose of the services are designed mainly to help the patient with daily living activities, to maintain their present physical and mental condition, or provide a structured or safe environment.

K. **Copayment or Copay** means the amount of the allowable charge for a covered service required to be paid by an Insured before benefits can be provided.

L. **Credible Evidence** means scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations or consensus among experts.

M. **Deductible** means the amount of the allowable charges for covered services required to be paid by an Insured before benefits can be provided. Amounts applied toward the Deductible are accumulated until a specified dollar maximum has been reached during a Benefit Period after which no additional Deductible amount is required for the remainder of that Benefit Period.

N. **Eligible Provider** means any of the following providers when services provided are within the scope of the licensure of the provider. NOTE: Providers recognized by Medicare as Independent Diagnostic Testing Facilities (IDTFs) are not considered Eligible Providers unless they meet the applicable criteria as set out in the definitions below.

1. **Ambulance Service** means any form of transportation specially designed, equipped, and intended to be used for the purpose of transporting ill or injured persons and is operated according to state and local laws which control the issuing of valid licenses or permits for the operation of an Ambulance Service.

2. **Ambulatory Surgical Center** means a facility that meets all of the following criteria: (1) is licensed by the proper licensing agency as an ambulatory surgical center; (2) is not a part of a Hospital; (3) provides hospital-type services for Outpatient surgery.

3. **Professional Provider** means any of the following health practitioners licensed or certified to provide health services in the state of Kansas:

   - Advanced Registered Nurse Practitioner (ARNP)/Advanced Practice Registered Nurse (APRN);
   - Any of the following when authorized to engage in private, independent practice under the laws of the state in which covered services are received:
     - Licensed Clinical Marriage and Family Therapist (LCMFT);
     - Licensed Clinical Professional Counselor (LCPC);
     - Licensed Clinical Psychotherapist (LCP);
     - Licensed Specialist Clinical Social Worker (LSCSW);
   - Audiologist;
   - Autism Specialist or Intensive Individual Service Provider as defined by the Kansas Department for Aging and Disability Services;

- Certified Diabetic Educator/Licensed Dietitian (for covered diabetic education services);
- Doctor of Chiropractic (DC);
- Doctor of Dental Surgery (DDS);
- Doctor of Medicine (MD);
- Doctor of Osteopathy (DO);
- Licensed Physical Therapist (LPT);
- Occupational Therapist;
- Doctor of Optometry (OD);
- Oral Surgeon;
- Physician Assistant (PA);
- Doctor of Podiatric Medicine (DPM);
- Psychologist licensed to practice under the laws of the state in which covered services are received; and
- Speech-Language Pathologist.
- Licensed Mental Health Technician (LMHT)
- Licensed Practical Nurse (LPN)
- Registered Nurse (RN)
- Respiratory Therapist (LRT)
- Athletic Trainer (AT)
- Naturopathic Doctor (LND)
- Licensed Radiological Technologist (LRTC)
- Master Level Psychologist (LMLP)
- Addiction Counselor (LAC)
- Licensed Master/Bachelor Social Worker (LMSW/LBSW)
- Dental Hygienist (LDH)
- Dietician (LD)

4. **Free-Standing Birthing Center** means a facility, operated by a licensed physician, that performs uncomplicated normal/routine (i.e., non-Cesarean) deliveries of newborns.
5. **Free-Standing Cardiac Catheterization Laboratory** means:

   - A facility approved by Medicare to perform diagnostic cardiac catheterization procedures
   - Performs only diagnostic cardiac catheterization procedures
   - Does so in a non-Hospital outpatient setting

6. **Free-Standing Dialysis Center** means a facility approved by Medicare to perform dialysis and related services.
7. **Free-Standing Imaging Center** means a facility operated by a licensed physician and approved by Medicare to perform specialized diagnostic and radiologic tests.
8. **Free-Standing Sleep Center/Laboratory** mean a facility that only performs sleep studies.
9. **Home Health Agency** means:

   - A public agency or private organization which is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's place of residence.
   - Has policies established by a group of professional personnel which governs the skilled nursing and therapeutic services which it provides
   - Maintains clinical records on all patients
   - Is licensed according to state and local laws
   - Is certified by Medicare

10. **Hospital** means any of the following types of institutions:

    - The acute care, psychiatric, rehabilitation and long-term acute care sections of a licensed general hospital
    - Other facilities licensed by their state of operation as a hospital that provide acute care services
    - Licensed privately operated psychiatric hospitals
    - Health care institutions operated by the State of Kansas or the United States government

    Hospital does **not** include any of the following, even if licensed as a hospital:

    - Ambulatory Surgical Centers
    - Clinics
    - Doctors' offices
    - Facilities that are primarily for the care of convalescents
    - Health resorts
    - Nursing homes
    - Private homes
    - Residential or transitional living centers
    - Residential treatment centers or similar facilities
    - Rest homes
    - Skilled nursing facilities

11. **Independent Laboratory** means a medical laboratory that is CLIA-certified Medicare to perform diagnostic and/or clinical tests and is independent of an Institutional Provider or a Professional Provider's office.
12. **Institutional Provider** means a Hospital, Medical Care Facility, or Ambulatory Surgical Center.
13. **Medical Care Facility** means a facility that is not a Hospital (see definition) but that is: an alcoholic treatment facility; a drug abuse treatment facility; or a community mental health center. To qualify as a Medical Care Facility, the facility must also be licensed by the State of Kansas to provide diagnosis and/or treatment of a Mental Illness or Substance Use Disorder.
14. **Other Eligible Providers** (as limited herein)
    a. Adjunct Providers means only the following providers that perform Covered Services under the direction of a Professional Provider.
        1. Certified Occupational Therapy Assistant
        2. Certified Physical (Therapy) Therapist Assistant
    b. Registered Nurse and Licensed Practical Nurses are Eligible Providers for Home Health Care and Private Duty Nursing only, but may also perform services incidental to and on behalf of services rendered and billed by a Professional Provider. Examples include, but are not limited to injections/immunizations, ECGs, and pulmonary function testing. Certified Registered Nurse Anesthetists (CRNA) are also Eligible Providers for anesthesia services.
    c. Orthopedic/Prosthetic Device Supplier
    d. Home Medical Equipment Supplier
    e. Infusion Therapy Providers licensed to provide infusion therapy in the state in which services are received, e.g., infusion suites, home infusion therapy providers.
    f. Specialty Pharmacy for dispensing Specialty Prescription Drugs eligible for coverage under the Comprehensive Program.
    g. Hospice means a Medicare Certified organization or agency providing comprehensive, continuous Outpatient and home-like Inpatient care for terminally ill patients and their families and is licensed to practice under the laws of the state in which covered services are received.

O. Eligible Provider for Mental Illness or Substance Use Disorders

- A Hospital;
- A Medical Care Facility;
- A Licensed Doctor of Medicine, or Doctor of Osteopathy;
- A psychologist licensed to practice under the laws of the state in which covered services are received;
- A Licensed Specialist Clinical Social Worker authorized to engage in private, independent practice under the laws of the state in which covered services are received;
- Advanced registered nurse practitioner;
- A Licensed Clinical Marriage and Family Therapist;
- A Licensed Clinical Professional Counselor;
- A Licensed Clinical Psychotherapist.

P. Except as limited is a phrase You will see before explanations of Covered Services. It means that all coverage under this Certificate is controlled by the conditions described in this Certificate, including exclusions.

Q. Experimental or Investigational refers to the status of a drug, device, medical treatment or procedure:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished and the drug or device is not Research-Urgent as defined in these General Definitions except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or
2. if Credible Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not Research-Urgent as defined in these General Definitions except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or
3. if Credible Evidence shows that the consensus among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not Research-Urgent as defined in these General Definitions except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment

of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or

4. if there is no Credible Evidence available that would support the use of the drug, device, medical treatment or procedure compared to the standard means of treatment or diagnosis except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

R. **Identification Card** means a card issued to identify You as an Insured of the Company.

S. **Inpatient** means a setting where services are provided when You have been admitted to a Hospital or Medical Care Facility.

T. **Insured** means the person named on the Identification Card.

Insured also means the following persons that have been duly enrolled in the Company's records according to the specifications set forth in the Enrollment and Effective Dates Section:

1. The husband or wife of the person named on the Identification Card; and
2. Each dependent child by birth, adoption, legal guardianship, or court-ordered custody of the Insured named on the Identification Card or such person's spouse, who is:
   a. Under 26, or
   b. Age 26 or over provided the child is unmarried and covered as a dependent child under a policy or certificate issued by the Company or other creditable coverage (as defined under HIPAA) upon reaching age 26, has no more than a 63-day gap in dependent or handicapped dependent coverage prior to application for coverage hereunder, and is incapable of self-support due to a severe handicap resulting from a physical condition or a Mental Illness or Substance Use Disorder prior to their 26th birthday. For such a child to be an Insured, You must request from and submit to the Company a special application within 63 days of the latter of the following: a) the child's 26th birthday (but no earlier than 60 days prior); or b) the first opportunity for the child to enroll for coverage hereunder or accrual of a special enrollment right pursuant to HIPAA. The Company will then determine the child's eligibility. If the child is eligible, the coverage will be effective according to the specifications set forth in the Enrollment and Effective Dates Section.

      The Company will request written proof from time to time related to this child's incapacity and dependence. This child's coverage will end when the child is no longer disabled or dependent.

Insured does not refer to persons who have been voluntarily disenrolled by the person named on the Identification Card.

U. **Intensive Care Unit** means a specialized room or area or section in a Hospital which includes:

- Beds in a distinctly identifiable unit that are used only for critically ill or injured patients
- A separate nursing staff, with a qualified Registered Nurse in 24-hour attendance while the unit is occupied ("Qualified" means the nurse has had special training in intensive care nursing.)
- Special supplies and equipment needed to care for critically ill or injured patients

V. **Medical Emergency** means a sudden and, at the time, unexpected onset of a health condition that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect to require immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. Medical Emergency does not include the onset of a health condition while an Inpatient.

W. **Medically Necessary** describes a service or supply performed, referred or prescribed by a provider in the most appropriate setting and consistent with the diagnosis and treatment of the patient's condition in accordance with generally accepted standards of medical practice in the United States based on credible scientific evidence and not primarily for the convenience of the patient, physician, or other health care provider.

X. **Medicare** means Title XVIII of the Social Security Act as amended now and in the future, any rules and regulations authorized by any agency authorized to administer that Act.

Y. **Mental Illness or Substance Use Disorder** means a disorder specified in the Diagnostic and Statistical Manual of the American Psychiatric Association IV (1994). This does not include any condition or problem that is designated in the DSM IV (1994) as a focus of clinical attention.

Z. **Non-Contracting Provider** means an Eligible Provider who has not entered into a Contracting Provider Agreement with Blue Cross and Blue Shield of Kansas.

AA. **Open Enrollment** means the period of time during which eligible persons who have not previously enrolled with the Company within the time periods specified, following their first opportunity or an event, as defined by state or federal law, that qualifies them for coverage, may do so. This time period is the 30 days preceding

the anniversary month of the Contract Holder. If agreed upon by the Contract Holder and the Company, different, additional or longer Open Enrollment Periods may be established.

BB. Outpatient means a setting where provided services are other than as an Inpatient in a Hospital or Medical Care Facility. These settings include but are not limited to the Outpatient department of a Hospital, an Ambulatory Surgical Center, a clinic or a Professional Provider's office.

CC. Rehabilitation Services means therapies that, when provided in an Inpatient or Outpatient setting, are designed to restore physical functions following an Accidental Injury or an illness.

DD. Research-Urgent means a drug, device, medical treatment or procedure that is otherwise excluded by this Certificate as Experimental or Investigational (see General Definitions and General Exclusions) but meet all the following criteria:

1. It is therapeutic (not diagnostic or supportive) treatment used to directly improve health outcomes for a condition that is either life threatening or severely and chronically disabling and that has a poor prognosis with the most effective conventional treatment.

   a. For purposes of Research-Urgent Benefits a condition is considered life threatening if it has a substantial probability of causing premature death and all other conventional treatments have failed.

   b. For purposes of Research-Urgent Benefits a condition is considered severely and chronically disabling if the individual with the condition is unable to perform even the functions that are required for daily life and if the severe disability is not expected to improve with the most effective conventional treatment.

2. There is Credible Evidence that the treatment may provide a clinically significant and substantial improvement in net health outcome compared to the most effective conventional treatment, or where conventional treatment has failed or is not medically appropriate.

3. Regardless of funding source, the drug, device, medical treatment or procedure is available to the Insured seeking it and will be provided within a well designed clinical trial conducted by the National Institute of Health, Inc. or by an institution or entity which the protocol for the drug, device, medical treatment or procedure has been approved by an Institutional Review Board that is in compliance with the ethical principles in: (a) The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research or the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, or (b) other appropriate ethical standards recognized by federal departments and agencies that have adopted the Federal Policy for the Protection of Human Subjects.

EE. Sound Natural Tooth means a tooth that is whole or properly restored; is without advanced periodontal disease and is not in need of the treatment provided for any reason other than an Accidental Injury.

FF. Utilization Review means an evaluation of the medical necessity, appropriateness, and efficiency of use of health care services, procedures, and facilities.

The claims review is done by consulting practicing Doctors in cooperation with Your Doctor.

GG. You and Your refer to the Insured.

Form GD-2142 1/15

ENROLLMENT AND EFFECTIVE DATES

A. Initial Establishment of Coverage

The Contract Holder (or employer if different) shall submit to the Company an individual application for each eligible employee electing coverage. These applications will be accepted if received by the Company within 60 days of the person's date of initial eligibility to enroll.

If the Contract Holder offers a choice of two or more optional health benefit programs, an Insured may elect only one of the programs offered.

For those who are enrolling at their initial opportunity, coverage will be effective on the first of the month following the initial opportunity to enroll as long as the application is received by the Company within 60 days of the person's initial opportunity to enroll.

For those who do not make application within the time periods set forth above, but who are enrolling in conjunction with an event, as defined by state or federal law, that qualifies them for coverage, such coverage will be effective on the first of the month following the event that qualifies them for coverage as long as the application is received by the Company within 60 days of the event except when the event is birth, adoption, placement for adoption, or discharge from the military in which case the effective date will be the date of the event.

B. Adding Dependents

The Contract Holder (or employer) shall notify the Company in writing when an Insured's coverage should be changed to either add or drop a dependent or dependents when such a change would result in the establishment of a different coverage type, e.g., employee only coverage to employee/spouse coverage or vice versa. If the notice of change is received by the Company within 60 days of the Insured's marriage date or the date of the event, as defined by state or federal law, which qualifies the dependent for coverage hereunder, such change will be accepted. Changes in coverage type will be the first of the month following the date the dependent became eligible for coverage.

C. Care for Newborns and Mothers

Inpatient services in a Hospital are covered for at least 48 hours following a vaginal delivery and at least 96 hours following delivery by a cesarean section for the newborn child of an Insured and the mother (if an Insured) of such newborn.

The Company has the right to determine the medical necessity of any length of stay beyond the 48-96 hours described above.

In the event that coverage hereunder provides benefits for only the parent(s) of the newborn child, coverage must be changed to a type that provides benefits for dependent children within the time period required for such change (as set forth above) in order for the newborn child's coverage to continue beyond the initial 48 or 96 hour periods described above.

Covered services received by the child prior to coverage being changed to a type that provides benefits for dependent children, will be treated as though they were services received by the parent Insured.

D. Newborn Child/Adopted Child Coverage

Notwithstanding any provision to the contrary, under existing coverage that provides benefits for two or more Insureds, a newborn of the person named on the Identification Card or the spouse of the person named on the Identification Card or a child (regardless of age) adopted by the Insured or placed in the Insured's home by a child placement agency as defined by state law for the purpose of adoption, is covered as follows:

1. In the case of natural newborns, newborns for which the petition for adoption has been filed within 31 days following birth, or newborns placed in the Insured's home within 31 days following birth, coverage will be effective and provided without charge for 31 days beginning on the date of birth.
2. In the case of adoptions subsequent to the first 31 days of birth, coverage will be effective and provided without charge for 31 days beginning on the date the petition for adoption was filed.
3. In the case of placement of a child in the Insured's home by a child placement agency as defined by state law for the purpose of adoption subsequent to the first 31 days of birth, coverage will be effective and provided without charge for 31 days beginning on the date of placement.

Under a coverage type that provides benefits for children, no change in coverage type is required. However, additional premiums may be required.

Under coverage that provides benefits for an employee or employee and spouse only, the coverage must be changed to a coverage type that would include the child in order for the child to have coverage beyond the first 31 days.

E. Dependent coverage pursuant to a Qualified Medical Child Support Order

Coverage will be effective on the first day of the month following the date on which the Company qualifies the order. Medical Child Support Orders must be qualified by the Contract Holder and the Company pursuant to specifications of federal and state law. The procedure for qualification is to timely submit the Medical Child Support Order to the Contract Holder for initial qualification or rejection. The Contract Holder will forward the order to the Company for qualification or rejection with notice to the parties to the order. If the order is qualified, an Identification Card, Certificate and claim form will be issued to the Alternate Recipient.

F. Coverage begins on the date this coverage becomes effective for the Insured as reflected in the records of Blue Cross and Blue Shield of Kansas and determined according to the provisions set forth in this Enrollment and Effective Dates section.

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G. Special Enrollment Rights

Special Enrollment Rights are recognized when an eligible employee, spouse, or dependent involuntarily loses group health plan or health insurance coverage in connection with designated qualifying events as outlined below or becomes eligible for state premium assistance as provided below, or when an eligible employee acquires a spouse and/or dependent(s). Under these circumstances, coverage may be added for certain individuals wishing to become covered hereunder if such individuals are otherwise eligible for coverage and enroll within 60 calendar days of the event creating the Special Enrollment Right.

The effective date of coverage arising from Special Enrollment Rights will be as provided in the applicable provision above in this Enrollment and Effective Dates section.

Special Enrollment Rights are recognized for the following qualifying events only:

1. Involuntary loss of other medical coverage in which:
   - -- The other coverage was the basis for You, Your spouse, and/or dependent(s) declining coverage hereunder; AND
   - -- The loss of other coverage occurred solely due to one of the following designated qualifying events: loss of eligibility for such coverage or exhaustion of COBRA or state continuation coverage. Note: Special Enrollment Rights are not recognized if coverage and/or eligibility was lost due to any of the following: failure on the part of the employee, spouse, or dependent, as applicable, to pay contributions/premiums on a timely basis, submission of fraudulent claims, or intentional misrepresentation of material information.
2. Complete cessation of employer contributions toward non-continuation group coverage
3. Marriage of employee
4. Birth
5. Adoption or placement for adoption
6. Becoming eligible for a state premium assistance program under Medicaid or a state Children's Health Insurance Program (CHIP).

Who accrues Special Enrollment Rights

The accrual of Special Enrollment Rights varies according to the qualifying events listed above. Special Enrollment Rights are recognized only for individuals as provided below:

1. For loss of other coverage or cessation of employer contributions: the employee, spouse, and any dependents losing such other coverage or employer contribution.
2. For marriage, birth, adoption, or placement for adoption: the employee, spouse, and any newly-acquired dependent(s) only.
3. For state premium assistance eligibility: the employee and any dependents.

Form EN-866 1/14

COMPREHENSIVE PROGRAM

A. Benefits

1. **Benefit Period:** The 12 month period beginning on April 1.
2. **Deductible per Benefit Period:** $500 for any one Insured, not to exceed $1,000 for all Insureds on family coverage (in aggregate). Charges incurred in the last three months of a Benefit Period that applied to the Deductible of that Benefit Period can also be applied to the Deductible of the next Benefit Period.
3. **Coinsurance:** After the Deductible has been met, the Company will make benefit payments for 80% of the allowable charge. When the amount You have paid in Coinsurance in the Benefit Period reaches $1,000 for any one Insured or $2,000 for all Insureds on family coverage (in aggregate), the amount payable for the rest of the Benefit Period will be 100% of the allowable charge.
4. **Annual Out-of-Pocket Maximum:** $6,350 for any one Insured not to exceed $12,700 for all Insureds on family coverage. No one Insured on family coverage will be required to contribute more than the single Annual Out-of-Pocket Maximum towards the family Annual Out-of-Pocket Maximum. Out-of-Pocket expenses include the Deductible, Coinsurance and Copayment provisions under the Comprehensive Program, Prescription Drug Program and Mail Order Prescription Drug Program. After You have reached the Annual Out-of-Pocket maximum, eligible services will be paid at 100% of the allowable charge for the remainder of the Benefit Period. If You are enrolled in a dental care program, Coinsurance applicable to the dental care program does not apply to this Annual Out-of-Pocket Maximum.
5. **Home or Office Visit Copay:** A Copay of $25 will apply to each home or office visit. Any amounts You pay to satisfy this Copay do not apply toward satisfaction of any other Deductible, Coinsurance, or Copayment/Copay, except amounts in excess of the allowable charge for a Home or Office Visit shall be used toward the satisfaction of Deductible, Coinsurance, or Copayments for other covered services rendered during the same Home or Office Visit. Such amounts shall not be credited towards applicable aggregate amounts for the Benefit Period.
6. **Immunizations and Injections:** Benefits for covered immunizations and injections provided on an Outpatient basis will be paid at 100% of the allowable charge.
7. **Outpatient Laboratory and Radiology Services**

   Services that are not associated with an Accidental Injury:

   Benefits for covered laboratory and radiology services provided on an Outpatient basis will be paid at 100% of the allowable charge up to a maximum payment of $300 per Insured per Benefit Period after which benefits are subject to the Deductible, Coinsurance and/or Copayment/Copay amounts required for other covered services.

   Services that are associated with an Accidental Injury:

   Benefits for covered laboratory and radiology services provided on an Outpatient basis will be paid at 100% of the allowable charge until the Enhanced Accidental Injury Benefit (see #9 below) has been exhausted. After the Enhanced Accidental Injury Benefit has been exhausted, all remaining allowable charges for covered laboratory and radiology services are subject to the Deductible, Coinsurance and/or Copayment/Copay amounts required for other covered services.
8. **Emergency Room Copayment:** A Copayment of $100 will apply to each Hospital emergency room visit (Applies only to Institutional Provider services, not to services of Professional Providers.) This Emergency Room Copayment is in addition to any other Deductible, Coinsurance or Copayment/Copay amounts. For services associated with an Accidental Injury, this Copayment shall not apply until the Enhanced Accidental Injury Benefit (see #9 below) has been exhausted. This Emergency Room Copayment is waived if the patient is admitted as an Inpatient within 24 hours to the same Hospital for treatment of the same condition.
9. **Enhanced Accidental Injury Benefit:** Payment will be made at 100% of the allowable charge for covered services associated with any and all Accidental Injuries incurred up to a maximum of $1,000 per Insured per Benefit Period.
10. **Preventive Health Benefits:** Each Insured is eligible to receive the following preventive services paid at 100% of the allowable charge when received from a Contracting Provider for preventive (i.e., not diagnostic or treatment) purposes. Preventive Health Services received from a Non-Contracting Provider will be subject to the cost-sharing requirements (including copayments, coinsurance and deductible), applicable hereunder, in a manner consistent with Section 2713 of Federal H.R. 3590 for:

    a. evidence-based items or services that have in effect, a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;

    b. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

c. with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

d. with respect to women, such additional preventive care and screenings not described in item (a) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph (including breast cancer screening and mammography screenings).

A list of the preventive services covered under this section is available on our website at www.bcbsks.com, or will be mailed to You upon request. You may request the list by calling the Customer Service number on Your Identification Card.

Note: Benefits for any prescription drug under this Preventive Health Benefits section will be provided only to the extent they are not available under other drug coverage You have through the Contract Holder.

11. **Any reduction made in allowable charges** due to the provider being non-contracting cannot be used to meet any Deductible, Coinsurance, Copayments and/or the Annual Out-of-Pocket Maximum if applicable.

12. **Mental Illness or Substance Use Disorders (Covered Services must be provided by an Eligible Provider for Mental Illness or Substance Use Disorders)**

    Benefits for Inpatient and Outpatient Mental Illness or Substance Use Disorder services that are Medically Necessary will be provided at the same payment level that is applicable to the service if it had been provided for a condition other than Mental Illness or Substance Use Disorder.

13. **Diabetic Education**

    Benefits for a covered diabetic education service will be subject to the same payment provisions as an office visit.

14. **Other Covered Services:** Unless otherwise specified, all covered services shall be subject to the applicable Deductible, Coinsurance, Copayments and/or other payment provisions described herein.

15. **Insured Responsibility:** Unless otherwise specified, all covered services shall be subject to the applicable Deductible, Coinsurance, Copayments and/or other payment provisions described herein.

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B. General

1. All coverage under this section is subject to the service having been ordered by a Professional Provider with the legal authority to order such service, furnished or performed and billed for by an Eligible Provider with the legal authority to provide such service, and is Medically Necessary.

2. You have the right to select Your own provider. However, the Company does not guarantee the availability of any service and benefits shall be provided according to the cost-containment policies and procedures applicable to Contracting Providers, regardless whether Your Provider is actually a Contracting Provider.

3. "Except as limited" is a phrase You will see before explanations of services. It is a reminder that the terms of this Certificate -- especially exclusions -- may restrict Your benefits.

4. Prior Authorization is required for some Prescription Drugs covered under this Comprehensive Program. A list of those drugs is available on www.bcbsks.com or by contacting customer service. To obtain prior authorization Your physician must provide appropriate records to the Company prior to providing services and the Company will authorize coverage if the medical necessity is supported. Failure to obtain prior authorization will not result in a denial of benefits if medical necessity is supported when the claim is adjudicated.

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C. Covered Services

1. **Hospital and Medical Care Facility services for Inpatients --** Except as limited, the following are covered:

   a. Room accommodation, dietary and general nursing service, nursery care.

      Limitation: If You occupy a private room, only the average semi-private room rate (based on the provider's rates for rooms with two or more beds) is covered.

   b. Intensive Care Unit facilities and services.

      Limitation: If You occupy an Intensive Care Unit room when it is not Medically Necessary but it is Medically Necessary for You to be in the Hospital, only the Hospital's average semi-private room rate (based on rates for rooms with two or more beds) is covered on such days.

   c. Operating room services.

d. Delivery room service. (Including the obstetrical and delivery expenses of the birth mother of a child adopted within 90 days of birth of such child).

e. Surgical preparatory and recovery room services.

f. Clinical laboratory and pathology services.

g. Diagnostic radiology services and Imaging studies.

h. Radiation therapy

i. Drugs approved for use in the United States by the U.S. Food and Drug Administration, except drugs approved for experimental use and drugs for take-home use.

j. Surgical dressings, splints, and casts.

k. Chemotherapy, other than High-Dose Chemotherapy, for malignant conditions. (See the Special Situations section for High-Dose Chemotherapy with Hematopoietic Support benefits.)

l. Prostheses that require surgical insertion into the body and are furnished and billed by the Hospital or Ambulatory Surgical Center. This does not include artificial eyes, ears, and limbs.

m. Setups for intravenous solutions.

n. Setups for blood transfusions, (including Blood plasma).

o. Oxygen and use of equipment for its administration.

p. Radioactive isotopes.

q. Electroencephalograms (EEGs) and electrocardiograms (EKGs).

r. Inhalation therapy/breathing treatment.

s. Physical or occupational therapy.

t. Anesthesia, including general anesthesia and facility charges for dental care provided to the following covered persons: (a) A child five (5) years of age and under; (b) A person who is severely disabled; (c) A person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided.

u. Hemodialysis.

v. Services for a Mental Illness or Substance Use Disorder.

Prior Authorization Requirement

Inpatient admissions to Hospitals and Medical Care Facilities require prior authorization by the Company unless the admission is for a Medical Emergency, a life-threatening condition, for obstetrical care or occurs outside the 50 United States.

You or Your Doctor will need to notify the Company to obtain the prior authorization. Notice should be given to the Company at least 72 hours in advance of the planned admission and should include: The patient's name, date of birth, identification number, telephone number, address, Hospital name, planned date of admission, reason for admission, admitting physician's name. The notification may be telephoned to the Company at the telephone number on the Insured's Identification Card.

The Company has the right to request and obtain whatever medical information it considers necessary to determine whether admission as an Inpatient is Medically Necessary. If it is, the Company will notify You, the Hospital and the admitting physician of approval. If inpatient admission is not deemed Medically Necessary You will be notified, as will be the Hospital and admitting physician. Prior authorization of an admission or any service is related solely to the medical necessity of the service and is not a determination of the eligibility of the service under other provisions of this Certificate.

If You fail to obtain a necessary prior authorization, the Company will review that admission for medical necessity. No coverage will be provided under this Program for services determined to be medically unnecessary. Only that portion of the inpatient claim that would normally be payable if services were received as an outpatient will be covered.

2. **Hospital Services for an Outpatient.**

   Except as limited, Covered Services by a Hospital for an Outpatient will include all services listed in C.1.c through v when the service is received in the Outpatient department of the Hospital.

3. **Ambulatory Surgical Center Services.**

   Except as limited, the services listed in C.1.c through u are covered when billed by an Ambulatory Surgical Center.

4. **Professional Provider Services.**

Except as limited, the following are covered:

Surgery and anesthesia services to include coverage for the administration of general anesthesia for dental care provided to the following covered persons: (a) A child five (5) years of age and under; (b) A person who is severely disabled; (c) A person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided.

Treatment of fractures and dislocations.

Biopsies and aspirations.

Endoscopic (scope) procedures.

Maternity services (including the obstetrical and delivery expenses of the birth mother of a child adopted within 90 days of birth of such child).

Medical (non-surgical) services for Inpatients in a Hospital or Medical Care Facility. (See 4.a for details of this benefit.)

Diagnostic radiology services and Imaging studies.

Diagnostic laboratory services.

Radiation therapy.

Chemotherapy, other than High-Dose Chemotherapy, for malignant conditions. (See 4.b for details of the standard chemotherapy benefit and the Special Situations section for High-Dose Chemotherapy with Hematopoietic Support benefits.)

Diagnostic radio isotope studies.

Electroencephalograms (EEGs) and electrocardiograms (EKGs).

Rehabilitation services. (See 4.d for details of this benefit.)

Home and office visits.

Immunizations, injections and infusions subject to any prior authorization requirements of this Certificate that are otherwise applicable to these services.

Allergy testing.

Transfusions (but not the cost of the blood itself).

Oral surgery and certain other dental services. (See 4.c for details of this benefit.)

Pap Smears.

Prescription contraceptive devices including placement and fitting of the device itself.

Surgical procedures for the implantation of Bone Anchored Hearing Aids (BAHA).

Services for a Mental Illness or Substance Use Disorder.

Coverage for Prostate Cancer Screening for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older. The screening may consist of a Prostate Specific Antigen (PSA) test and/or a digital rectal examination.

Coverage for services related to diagnosis, treatment and management of osteoporosis for individuals with a condition or medical history for which bone mass measurement is medically necessary for such an individual. Coverage is subject to the same Deductible, Coinsurance and other limitations as apply to other covered services.

Diagnosis and treatment of cause of infertility

a. The covered Medical (Non-Surgical) Services for Hospital or Medical Care Facility Inpatients include:

(1) Visits by the attending Doctor.

Limitations:

(a) During a stay for surgery, Medical (Non-Surgical) Services given by a Doctor other than the surgeon will not be covered unless they are Medically Necessary.

(b) If non-surgical treatment is given by two (2) or more Doctors at the same time, only one (1) Doctor will be paid for services.

(2) Consultations.

The first visit of a Doctor to give professional advice about Your condition is covered if the visit is requested by the attending Doctor and Your condition requires special skill or knowledge. This

consultation benefit is normally limited to one (1) during each Hospital stay. However, additional consultations may be approved with individual consideration of Your condition.

Consultations required by Hospital rules and regulations are not covered.

(3) Well Baby Care.

This covered service is for care of a well newborn during the mother's stay. It includes the normal Inpatient medical care for a newborn. The child must meet the applicable Deductible then this service is payable at the applicable Coinsurance amount.

b. Chemotherapy for malignant conditions.

(1) Chemotherapy administration services.

(2) Chemotherapy drugs that are injected or given intravenously or taken by mouth and under the direct supervision of Your Doctor. Prescription Drugs for chemotherapy are covered under the health benefits section of this coverage only if You are not enrolled in prescription drug coverage.

(3) Home and office visits for treatment of an adverse reaction to chemotherapy.

(4) Any other services related to chemotherapy that are specifically stated as covered.

c. Oral Surgical Services and Services for Accidental Injuries to Sound Natural Teeth, limited to:

(1) Surgical procedures of the jaw and gums.

(2) Removal of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

(3) Removal of exostoses (bony growths) of the jaw and hard palate.

(4) Treatment of fractures and dislocations of the jaw and facial bones.

(5) Surgical removal of impacted teeth.

(6) Treatment (including replacement) for damage to or loss of Sound Natural Teeth caused by an Accidental Injury.

(7) Intra oral dental imaging services in connection with covered oral surgery if such oral surgery occurs within 30 days of the imaging service(s.)

(8) General anesthesia.

(9) Cylindrical endosseous dental implants, mandibular staple implants, subperiosteal implants and the associated fixed and/or removable prosthetic appliance when provided because of an Accidental Injury.

(10) Cylindrical endosseous dental implants, mandibular staple implants, subperiosteal implants and the associated fixed and/or removable prosthetic appliances following surgical resection of either benign or malignant lesions (NOT including inflammatory lesions).

Exclusions: The extraction of teeth (except impacted teeth); fillings; prophylaxis (cleaning); scaling, scraping and/or root planing; dentures; straightening of teeth; and other dental services not listed as covered.

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d. Covered Rehabilitation Services. Except as limited, the following Rehabilitation Services are covered on both an Inpatient and Outpatient basis:

(1) Physical medicine modalities, including but not limited to: correction or adjustment by manual, mechanical, electrical or physical means (including the use of light, heat, water or exercise) of structural imbalance, distortion, subluxation or displaced tissue of any kind or nature of the human body.

(2) Physical therapy.

(3) Occupational therapy. (The materials used are excluded.)

(4) Speech therapy, limited to one service per day up to a maximum benefit of 90 daily services per Insured per Benefit Period. This limitation is not applicable to Mental Illness or Substance Use Disorders.

(5) Respiratory therapy.

(6) Neuropsychological testing.

(7) Cardiac Rehabilitation program or provider approved by the Company.

(8) Pulmonary rehabilitation program or provider approved by the Company.

Limitations:

(1) Services are covered only if they are expected to result in significant improvement in the Insured's condition. The Company, with appropriate medical consultation, will determine whether significant improvement has occurred.

(2) Cardiac and pulmonary rehabilitation programs are covered services only when provided by a provider whose program has been approved by the Company. You can obtain a list of approved programs, by calling the Customer Service number on Your Identification Card.

Exclusions:

(1) Vocational rehabilitation. Vocational rehabilitation is a process to restore or develop the working ability of the physically, emotionally or mentally disabled patients to the extent that they may become gainfully employed. This may include services provided to determine eligibility or provide treatment for vocational rehabilitation, to include but not limited to counseling, work trials and driving lessons.

(2) Therapies designed to evaluate and assist an individual in developing a program to complete their work and prevent physical damage or reinjury.

(3) Cognitive therapy. Cognitive therapy is a service provided to retain or enhance information processing due to brain damage or brain dysfunction which alters the way in which a person perceives or responds. These therapies include, but are not limited to treatment of memory loss, problem solving difficulties, short attention span, or inability to scan visually. Cognitive therapy services may also be known as multi-sensory programs, applied behavioral analysis, educational therapies, perceptual therapies, sensory integration, auditory integrative training, augmentative/alternative communication, discrete training trials, developmental therapy, or similar therapies. For the purposes of this Certificate, cognitive therapy services do not include neuropsychological testing.

e. Services for Autism Spectrum Disorder

(1) Definitions:

- Applied Behavior Analysis (ABA) means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior;
- Autism Spectrum Disorder (ASD) means a neurobiological disorder which includes autistic disorder, Asperger's disorder, pervasive developmental disorder not otherwise specified, Rett's disorder, and childhood disintegrative disorder when diagnosed by a licensed physician, licensed psychologist, or licensed specialist clinical social worker.

(2) Covered Services:

- ASD services include:
  - diagnostic evaluations performed by a licensed physician, licensed psychologist or licensed specialist clinical social worker;
  - treatment, including ABA therapy, limited to care, services, and related equipment prescribed or ordered by a licensed physician, licensed psychologist or licensed specialist clinical social worker;
- ABA therapy is limited to 1,300 hours per benefit period for four years beginning on the later of the date of diagnosis or January 1, 2015, for any covered individual diagnosed with Autism Spectrum Disorder between birth and five years (prior to the attainment of 60 months) of age; and
- 520 hours of ABA therapy per benefit period for any covered individual less than 12 years of age.
- Only those services actually provided on an hourly basis or fractional portion thereof by certified ABA providers are covered.
- ABA therapy services require prior authorization by the Company. You or Your doctor will need to notify the Company to obtain prior authorization. Notice should be given to the Company at least 72 hours in advance of the planned ABA therapy services and should include: the patient's name, date of birth, identification number, telephone number, address, the name of the prescribing physician, psychologist or licensed clinical specialist social worker and the date the patient was first diagnosed with autism spectrum disorder.

  The Company has the right to request and obtain whatever medical information it considers necessary to determine whether the ABA therapy services are Medically Necessary. If it is, the

Company will notify You and the treating provider of approval. If ABA treatment is not deemed Medically Necessary You and the treating provider will be notified.

If You fail to obtain a necessary prior authorization, the Company will review the ABA services for medical necessity. No coverage will be provided under this Program for services determined to be medically unnecessary.

(3) Exclusions:

- Full or partial day care or habilitation services, community support services, services at intermediate care facilities, school-based rehabilitative services, or overnight, boarding and extended stay services at facilities for autism patients; or
- Services that are otherwise provided, authorized or required to be provided by public or private schools receiving any state or federal funding for such services.

5. **Other Covered Services.**

Except as limited, the services listed below are covered:

a. Orthopedic, orthotic and prosthetic devices and appliances, including orthopedic braces, artificial limbs, artificial eyes, auditory osseointegrated devices.

Limitations:

(1) Benefits are not provided for eyeglasses and contact lenses.

Exception

- Benefits are available for the initial eyeglasses/contacts following surgery for cataracts, aphakia, or pseudophakia.
- An Insured under 12 years of age is eligible for subsequent eyeglasses/contacts following cataract surgery when there is a minimum change of .25 diopter.

(2) Benefits are not provided for hearing aids, hair prosthesis or dental appliances including plates, bridges, prostheses or braces.

(3) Benefits are not provided for items of wearing apparel except coverage is available for two post-mastectomy bras per Insured per Benefit Period. A post-mastectomy bra is a bra that is specifically designed and intended to support single or bilateral breast prostheses.

(4) Benefits are limited to the allowable amount for a basic/standard appliance which provides the essential function(s) required for the treatment or amelioration of the medical condition.

(5) Charges for deluxe or electrically operated appliances or devices are not covered beyond the allowable amount for basic/standard appliances. Deluxe describes medical devices or appliances that have enhancements that allow for additional convenience or use beyond that provided by a basic/standard device or appliance.

(6) Benefits are not provided for custom or over-the-counter orthotic devices, appliances including shoe inserts.

b. Medical Equipment and Supplies. Equipment for use in Your home is covered if:

- Prescribed by a Doctor for use in the home
- Not provided by a Hospital
- Serves a medical purpose
- Not an item that would ordinarily be of use to a person in the absence of a medical need. This includes items such as hemodialysis equipment, wheelchairs and hospital-type beds.

Medical Supplies: Coverage is also available for certain supplies as designated by the Company. You can obtain a list of covered supplies by contacting Customer Service at the number listed on Your Identification Card.

Limitations:

(1) Items for comfort or convenience are not covered. Included within the definition of convenience items are:

(a) Pieces of equipment used to provide exercise to functioning and non-functioning portions of the body when leased, purchased, or rented for use outside a recognized institutional facility.

(b) Those pieces of equipment designed to provide the walking capability for individuals with non-functioning legs

(2) The Company has the right to decide whether to provide for the rental or purchase of a covered item, to apply rental payments to purchase, and to stop covering rental when the item is no longer Medically Necessary.

(3) Benefits are limited to the allowable amount for a basic/standard item which provides the essential function(s) required for the treatment or amelioration of the medical condition.

(4) Charges for deluxe or electrically operated medical equipment are not covered beyond the allowable amount for basic/standard items. Deluxe describes medical equipment that has enhancements that allow for additional convenience or use beyond that provided by basic/standard equipment. For example, if an electric wheelchair is obtained, the benefit will not exceed the amount for a hand-operated wheelchair.

c. Allergy Antigens

d. Services associated with intravenous drug treatment including prescription drugs, supplies, and equipment and nursing services by Infusion Therapy Providers.

e. Diabetic Management.

(1) Equipment used exclusively with diabetes management.

Limitations:

Benefits are limited to the allowable amount for a basic/standard item; charges for deluxe items are not covered.

(2) Supplies: Coverage for diabetic supplies is provided under the Comprehensive Program only if the Insured does not have prescription drug coverage for such supplies. For purposes of this provision, diabetic supplies means syringes, needles, lancets, test strips and solutions, calibration strips, solutions and insulin pump supplies used exclusively with diabetic management.

(3) Outpatient self-management training and education, including medical nutrition therapy, for insulin dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes when provided by a certified, registered or licensed health care professional with expertise in diabetes and the diabetic (1) is treated at a program approved by the American Diabetes Association or American Association of Diabetes Educators; (2) is treated by a person certified by the national certification board of diabetes educators; or (3) is, as to nutritional education, treated by a licensed dietitian pursuant to a treatment plan authorized by such healthcare professional.

f. Genetic Molecular Testing only in the following situations:

(1) When there are signs and/or symptoms of an inherited disease in the affected individual, there has been a physical examination, pre-test counseling, and other diagnostic studies, and the determination of the diagnosis in the absence of such testing remains uncertain and would impact the care and management of the individual on whom the testing is performed.

(2) BRCA 1 and/or BRCA 2 testing when there are signs and/or symptoms of an inherited disease as specified above, or when signs and/or symptoms are not present but the testing has been prior authorized according to the criteria established by the Company.

As used herein, "Genetic Molecular Testing", means analysis of nucleic acids used to diagnose a genetic disease, including but not limited to sequencing, methylation studies and linkage analysis.

6. **Emergency Services.** Services necessary to provide an Insured with evaluation and stabilizing treatment when provided for a Medical Emergency.

7. **Ambulance Service.**

Except as limited, Ambulance Services that are Medically Necessary are covered:

- To the place of treatment following an Accidental Injury or Medical Emergency
- To a Hospital for care as an Inpatient
- From a Hospital where You have been an Inpatient
- For transfer of an Inpatient to another Hospital for care as an Inpatient.
- A 500-mile radius of the place where You are picked up, by the least expensive means or transport that meets the medical need.

D. Special Situations

1. **Case Management**

Case Management is a process conducted by the Company which:

a. identifies cases involving an Insured which presents either the potential for catastrophic claims or a utilization pattern that exceeds the norms and demonstrates or has the potential for atypical utilization of services;

b. assesses such cases for the appropriateness of the level of patient care and the setting in which it is received;

c. reviews services requested by the provider for potential alternative use of benefits or coordination of existing benefits; and

d. evaluates and monitors the requested services for cost efficient use of benefits.

The services may include both covered services and non-covered services with the exception of specifically stated exclusions. Total benefits paid for such services shall not exceed the total benefits to which the Insured would otherwise be entitled under the terms of this Certificate.

If the Company elects to provide benefits for an Insured in one case, it shall not obligate the Company to provide the same or similar benefits for the same or another Insured in the same or another case.

Participation in Case Management is voluntary. The Insured may withdraw at any time and return to the stated benefits of this Certificate.

2. **Research-Urgent Benefits.** Drugs, devices, medical treatments or procedures that are otherwise excluded as Experimental or Investigational but meet the criteria for Research-Urgent benefits as provided in the General Definitions section. No benefits shall be available under this section for any Research-Urgent drug, device, medical treatment or procedure (or related services) that are provided free of charge to trial participants or for any Research-Urgent drug, device, medical treatment or procedure that are excluded by another provision of this Certificate.

3. **Penile Prosthesis for Physiological Impotence.**

Benefits are provided for a penile prosthesis required for physiological (not psychological) impotence, subject to advance approval by the Company only in the following situations: trauma, radical pelvic surgery, diabetes, Peyronie's Disease, vascular or neurological diseases when individual situation warrants coverage in the Company's opinion.

To request advance approval, a written report prepared by Your Doctor must be submitted to the Company. The Company has the right to request and obtain medical information it considers needed to determine whether benefits should be approved or not.

Benefits are not provided for services of sleep laboratories for nocturnal penile tumescence testing.

4. **Home Health Care and Private Duty Nursing Services**

Covered Home Health Care services include services provided by a Medicare certified Home Health Agency.

An Insured must be homebound for the following services to be eligible. An Insured will be considered to be homebound if they have a condition due to illness or injury for which leaving the home is medically contraindicated. The Company has the right to determine whether the patient is homebound.

All Home Health Care and Private Duty Nursing services require Prior Authorization by the Company in order to be eligible for benefits. If prior approval is not obtained, the Company has the right to request medical records to review to determine whether services are eligible under this Certificate.

a. Covered Services include:

1. Nursing care provided in the Insured's home by:

- A Registered Nurse
- A Licensed Practical Nurse
- A licensed vocational nurse

2. Services provided in the Insured's home by a Licensed Social Worker.

3. Private Duty Nursing services provided by a state licensed nursing agency or state licensed nurse for Medically Necessary services provided on an hourly basis to a homebound Insured.

b. Covered Services do not include services:

- Provided by a member of the Insured's immediate family;
- Provided by a person who normally lives in the Insured's home; or
- Which are Custodial/Maintenance care. The Company has the right to determine which services are Custodial/Maintenance care.

c. Services that do not require that the patient be homebound.

- Home care education associated with diabetes, colostomy care, wound care, IV therapy, or any other condition or treatment which the Company has determined is appropriate for home care education, when provided by a Medicare certified Home Health Agency. Benefits for educational services will be limited to no more than three home care education visits per Benefit Period for which home care education is appropriate.
- Home infusion and related services. These services can be provided by either a Medicare certified Home Health Agency, state licensed nursing agency or state licensed nurse.

5. **Hospice Care**

Definitions

a. **Hospice Care Plan** means a coordinated plan of care which provides Palliative Care for the Hospice Patient. This plan is designed to provide care to meet the special needs during the final stages of a terminal illness.

b. **Palliative Care** means treatment directed at controlling pain, relieving other physical and emotional symptoms and focusing on the special needs of the Hospice Patient and the Hospice Patient's Family, as they experience the dying process rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

c. **Hospice Patient's Family** means the Hospice Patient's immediate family, including a spouse, brother, sister, child or parent. Other relations and individuals with significant personal ties to the Hospice Patient may be designated as members of the Hospice Patient's Family by mutual agreement among the Hospice Patient, the relation or individual and the Hospice Team.

d. **Hospice Patient** means a patient diagnosed or referred by a physician, to a Hospice and who alone, or in conjunction with designated family members, has requested and received admission into a hospice program. Written certification by the patient's Doctor that the Hospice Patient has a life expectancy of 6 months or less is required.

e. **Hospice Team or Interdisciplinary Group** means the attending physician and the following hospice personnel: physician, registered or licensed practical nurses, licensed social workers, pastoral or other counselors. Providers of special services, such as mental health, pharmacy, home health aides, trained volunteers and any other appropriate allied health services shall also be included on the Interdisciplinary Group as the needs of the patient dictate.

Election of Hospice Benefits

In order for You to receive Hospice benefits for the covered services listed below, the Company must receive a copy of a hospice election form and the informed consent form from a Medicare certified Hospice. If these forms are not received, benefits of this Hospice Care provision will not be available and services You receive will be processed according to the benefits and limitations of this Certificate other than those listed in this Hospice Care provision.

All Hospice Care services require prior authorization by the Company in order to be eligible for benefits. If prior approval is not obtained, the Company has the right to request medical records for review to determine whether services are eligible under this Certificate.

Eligibility of Services

a. Once Hospice benefits are elected, coverage for the terminal illness and related conditions is limited to the coverage listed in this Hospice Care provision unless specified otherwise.

b. Coverage under this Hospice Care provision is available only for Palliative Care. If Blue Cross and Blue Shield of Kansas determines the care provided is not Palliative Care, benefits of this Hospice Care provision cease to be available.

c. When covered services are not available from a Hospice provider (for example individual psychotherapy services) and the Insured is referred to another provider of service, benefits are not available under this Hospice Care provision, except as provided under the description of Covered Services.

In situations b. and c. listed above when services are not eligible for benefits under the Hospice Care provision, the services will be processed according to the benefits and limitations of this Certificate other than those listed in this Hospice Care provision.

Covered Services

Covered Hospice Care includes the following services provided by a Medicare certified Hospice (or an Institutional or Professional Provider under the direction of a Medicare certified Hospice and not charging

for services separately from the Hospice). Covered services also include the following when provided for routine home care according to the Hospice Care Plan:

a. Nursing care.
b. Home health aide services.
c. Social work services.
d. Pastoral services.
e. Volunteer support.
f. Bereavement services.
g. Counseling services.
h. Dietary and nutritional counseling/services.
i. All drugs, medical supplies, and equipment related to the terminal illness.
j. Speech therapy.
k. Occupational therapy.
l. Physical therapy.
m. Lab fees.
n. Medical equipment.
o. Educational services.
p. Other services and supplies provided through the Medicare certified Hospice (excluding Inpatient Hospital care and Inpatient or Outpatient physician's visits) recommended by a Doctor.

6. **Human Organ or Human Tissue Transplants.**

Benefits are provided (subject to the prior authorization provision set forth below) for the following human organ transplants:

- Cornea
- Heart
- Heart-lung
- Kidney
- Pancreas
- Liver
- Lung (whole or lobar, single or double)
- Small intestine
- Mulitvisceral transplants

There is no coverage hereunder for any transplant not specifically listed as covered or for supplies or services provided directly for or relative to human organ transplants not specifically listed as covered. No benefits will be provided for multiple organ transplant combinations not listed even when one or more of the organs involved is listed as a covered transplant.

Benefits for a human organ transplant will be available for a live donor (whether or not an Insured), if the recipient is an Insured, unless the donor has other coverage.

NOTE: See Prior Authorization Requirement below.

7. **High-Dose Chemotherapy with Hematopoietic Support (commonly referred to as bone marrow transplant and/or peripheral stem cell transplant).** Benefits are available only when precertified and the treatment particular for the Insured's condition is not Experimental or Investigational.

Benefits will be available for the costs associated with the donor search and acquisition of bone marrow or peripheral stem cells when a related donor is not available.

NOTE: Prior Authorization Requirement for Human Organ or Human Tissue Transplants and High-Dose Chemotherapy with Hematopoietic Support

Human organ and human tissue transplants (except cornea transplants), and high-dose chemotherapy with hematopoietic support, require advance written authorization from the Company.

You or Your Doctor must give written notice to the Company at the time as You become a candidate for a human organ transplant or re-transplant or for the high-dose chemotherapy with hematopoietic support.

The Company has the right to require, request and obtain information from Your Doctors and other health care providers involved in the performance of the transplant or re-transplant or the high-dose

chemotherapy procedure with hematopoietic support, and to determine whether or not to authorize benefits based on such information.

The Company's determination of whether or not to authorize benefits will be based on factors such as (but not limited to):

- Provider and facility qualifications
- Comparative costs of the proposed providers and facility

Notwithstanding any contradictory provisions in this document addressing allowable amounts, the Company reserves the right to limit benefits to the lowest allowable amount including organ or tissue acquisition cost which would be accepted by another facility that contracts with the Company to provide these services. Any balance will be the obligation of the Insured.

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8. **Temporomandibular Joint Dysfunction Syndrome.**

a. **Definitions.** For the purposes of this Certificate, the following terms have these meanings:

(1) Temporomandibular Joint Dysfunction Syndrome (TMJ) means a condition involving misalignment or imbalance in the relationship of the person's lower jaw (mandible) to the upper jaw (maxilla), with related spasm of the muscles of mastication (chewing). In this Certificate the terms Craniomandibular Cervical Pain (CRMP), Craniomandibular Facial Pain (CMFP), or Myofascial Pain Dysfunction Syndrome (MFPD) shall have the same meaning and benefits as Temporomandibular Joint Dysfunction Syndrome.

(2) "Treatment Plan" means Your dentist's written report of recommended treatment.

b. **Benefits for Temporomandibular Joint (TMJ) Dysfunction Syndrome**

To the extent this Certificate provides benefits for office visits, diagnostic dental imaging services, etc. for medical conditions, the following services are also covered under the medical (not dental) coverage of this Certificate, applying appropriate Deductibles, Coinsurances, Copayments/Copays, shared payments:

(1) Only one of the following are eligible for benefits and will be subject to the Home or Office Visit payment provisions:

(a) A clinical evaluation, to include examination, history, ordering of necessary diagnostic procedures (such as radiographs, study models if necessary, muscle testing), evaluation of results and consultation with the patient.

(b) A total diagnostic evaluation including, but not limited to, history, examination, radiographs, study models and a patient consultation.

(2) Diagnostic services, including but not limited to:

- Panoramic radiographs
- Cephalometric radiographs with tracing
- Temporomandibular joint tomography
- Temporomandibular joint arthrography
- Skull series; computerized tomography of temporomandibular joint
- Manual muscle testing procedures; and

One of the following:

- Electromyography of cranial supplied nerves
- Electronic computerized neuromuscular testing
- Oscilloscopic neuromuscular testing

The maximum benefit payment (after application of any payment provisions) will be the Company's allowable amount for conventional electromyography, or neuromuscular-type test.

(3) Non-surgical initial treatment procedures (reversible Phase I) limited to:

(a) Orthopedic repositioning appliances (maxillary or mandibular).

(b) Orthopedic (orthotic) splints (such as nite-guards, biteblocks, bite openers, bite plates, muscle de-programmer).

(c) Physical therapy procedures (limited to transcutaneous electrical nerve stimulators, Galvanic stimulation, ultrasound, diathermy).

(d) Trigger point injections.

These services are subject to the provisions of the Insured's medical benefits program.

Exclusions: benefits do not include:

- Equilibration of occlusion
- Coronoplasty
- Occlusal adjustment
- Slides and/or photographs
- Non-prescription drugs
- Vitamins
- Nutrition supplements
- Stretching and other exercises
- Coolant sprays
- Rental or purchase of transcutaneous electrical nerve stimulators
- Office visits
- Periapical, bitewing and full-mouth radiographs
- Moist heat therapy
- Hot packs
- Massage, either manual or by machine
- Acupuncture
- Cold packs
- Range of motion treatments
- Diet survey
- Nutrition counseling
- Orthodontic treatment, including both fixed and removable appliances used for the purpose of moving teeth

(4) Surgical procedures, subject to the appropriate Deductible, Coinsurance, Copayment/Copay, and shared payments of this Certificate, must be prior authorized by the Company based on a Treatment Plan. Requests for authorization will be reviewed based on: diagnosis (the condition must be treatable by surgery); the patient's age; presence of debilitating pain; efficacy of conservative treatment; diagnostic records and description of the proposed surgical procedure.

(5) Final stabilization non-surgical (Irreversible Phase II) treatment.

Benefits for Phase II services, such as appliances, crowns and replacement of missing teeth, may be covered under Your Dental Care Program. If You do not have a Dental Care Program, there are no benefits for these services.

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PRESCRIPTION DRUG PROGRAM

A. General

1. Benefits of the Prescription Drug Program apply to Insureds enrolled for such coverage under the Certificate.
2. **Company Not Liable.** The Company will not be liable for any acts or wrongs of any party related to the sales, compounding, dispensing, manufacturing, or use of any Prescription Drug or insulin. This includes any claim, injury, demand, or judgment based on tort or other grounds (including warranty of merchantability).
3. **Your Pharmacy.** You have the right to select Your own Pharmacy. However, the Company does not guarantee the availability of any drug or supply and does not itself furnish Prescription Drugs. Also, coverage may be limited or unavailable for certain Pharmacies or Specialty Pharmacies as provided below.

B. Definitions

1. **Brand** means a Prescription Drug that is or has been marketed under patent protection.
2. **Compound** means a Prescription Drug: a) that is manufactured by a Pharmacy when no suitable commercial alternative is available; b) for which the main active ingredient is a covered Prescription Drug; and c) for which the purpose is solely to prepare a dose form that is Medically Necessary.
3. **Copayment** means the portion of the charge for a covered Prescription Drug You are responsible for each time Your Prescription Order is filled or refilled.
4. **Diabetic Supplies** means syringes, needles, lancets, test strips and solutions, calibration strips, solutions, and insulin pump supplies used exclusively with diabetic management.
5. **Formulary** means a list of both Brand and Generic Prescription Drugs reviewed and updated by the Pharmacy Benefit Manager and Therapeutics Committee which is comprised of physicians and Pharmacists. Prescription Drugs are selected for inclusion on the Formulary based on safety, efficacy and cost effectiveness. The Formulary is subject to periodic review and modification.

   The Formulary applies only to Prescription Drugs covered under this Program. The Formulary does not apply to Inpatient medications or to medications administered by a Professional Provider. The level of benefits You receive under this Program will be affected by a Prescription Drug's Generic/Brand status on the Formulary.

   To access the Formulary, visit our website at www.bcbsks.com or call Customer Service at the telephone number listed on Your Identification Card.
6. **Generic** means a Prescription Drug that: a) is equivalent to a Brand Drug, b) is available after the patent on that Brand Drug has expired and c) is available from more than one source. Equivalent means therapeutic equivalent as determined by the U.S. Food and Drug Administration.
7. **Pharmacist** means a person registered or licensed under his or her State's laws to dispense Prescription Drugs and/or administer vaccines and immunizations.
8. **Pharmacy** means an establishment registered or licensed where Prescription Drugs are dispensed by a Pharmacist. Pharmacies are further classified as:
   a. **Contracting Pharmacy** means a Pharmacy which has entered into a written network participation agreement with Blue Cross and Blue Shield of Kansas and/or a Pharmacy Benefit Manager.
   b. **Contracting Specialty Pharmacy** means a Contracting Pharmacy which has entered into a written network participation agreement with Blue Cross and Blue Shield of Kansas and/or a Pharmacy Benefit Manager to provide Specialty Prescription Drugs.
   c. **Non-Contracting Pharmacy** means a Pharmacy which has not entered into a written network participation agreement with Blue Cross and Blue Shield of Kansas or a Pharmacy Benefit Manager.
9. **Pharmacy Benefit Manager (PBM)** means an entity with which Blue Cross and Blue Shield of Kansas contracts for the provision of administrative, utilization review and network services for the covered drug and supplies under this Program.
10. **Prescription Drug** means a drug approved for general use in the United States by the U.S. Food and Drug Administration, assigned a National Drug Code (NDC) number and dispensed in compliance with federal or state laws pursuant to a Prescription Order or refill.
11. **Prescription Order** means the request Your Doctor may legally issue for a Prescription Drug.
12. **Prior Authorization** is the process of obtaining approval for certain Prescription Drugs based on criteria established by the Company. Prior Authorization is required for some Prescription Drugs covered under this

Program. Prescription Drugs requiring Prior Authorization are listed on the Formulary. Prescription Drugs may be added or deleted from the list on a quarterly basis.

13. **Specialty Prescription Drug** means Prescription Drugs or classes of Prescription Drugs that are designated by the Company as Specialty Drugs. These include, but are not limited to, drugs that are self-administered by injection, inhaled or taken orally; drugs that may require special handling and storage; drugs that may require strict compliance and patient support; and drugs that may be available through limited distribution arrangements. The list of Specialty Prescription Drugs is on the Formulary.
14. **Utilization Review** means a claims review process of medical necessity. It includes the review of the medical need for prescription and quantity prescribed and the Prescription Orders to verify that Prescription Drugs were dispensed as ordered.

C. Amount of Benefits

The Copayment amounts are:

Insulin	$15.00
Generic Prescription Drug	$15.00
Brand Formulary Prescription Drug	$30.00
Brand Non-Formulary Prescription Drug	$45.00
Compound Prescription Drug	$45.00

Preventive Immunizations (as described in Preventive Health Benefits in the Comprehensive Program section of this document) are paid at 100% of the allowable charge when received from a Network Provider.

Annual Out-of-Pocket Maximum: The Annual Out-of-Pocket Maximum in the Comprehensive Program section is applicable to Prescription Drug benefits. Out-of-Pocket expenses include the Deductible, Coinsurance and/or Copayment provisions under the Comprehensive Program and Prescription Drug Program.

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D. Covered Services

Except as limited, Prescription Drugs are covered when ordered by Your Doctor and dispensed by a Pharmacy based on a Prescription Order.

The covered Prescription Drug services include:

1. The filling of the initial Prescription Order.
2. Refills of the Prescription Order as authorized by Your Doctor within one year from the date of the initial Prescription Order but not before at least two-thirds (2/3) of the previously purchased supply has been exhausted. Authorization for an early refill to accommodate a vacation supply may be obtained by contacting the Company, but not more often than two times per Insured during any 12-month period.
3. The reissue of a Prescription Order by Your Doctor for a medication previously ordered, but not before at least two-thirds (2/3) of the previously purchased supply has been exhausted. Authorization for an early reissue to accommodate a vacation supply may be obtained by contacting the Company, but not more often than two times per Insured during any 12-month period.

Limitations:

a. The benefit for Prescription Drugs pursuant to a Prescription Order shall be limited to a supply sufficient for 34 consecutive days of therapy based on criteria established by the Company, except Prescription Drugs designated by the Company, that are prescribed for certain chronic conditions, may be dispensed in supplies up to a maximum of 100-unit dose quantities, but not to exceed a supply sufficient for 100 consecutive days of therapy, if such is greater than a 34 consecutive day supply.

b. Prior Authorization is required for some Prescription Drugs covered under this Program.

c. A Pharmacy is not required to fill a Prescription Order which in the Pharmacist's judgment should not be filled.

d. Coverage for Specialty Prescription Drugs will be limited to a supply sufficient for 34 consecutive days of therapy. These Prescription Drugs are listed on the Formulary. A list of these Prescription Drugs may also be obtained by contacting Customer Service at the number listed on Your Identification Card. Prescription Drugs may be added or deleted from the list on a quarterly basis.

e. Some excluded Prescription Drugs are listed on the Formulary. These exclusions are in addition to drugs or classes of drugs excluded under other provisions of this Certificate.

4. Growth hormone therapy is covered only under one of the following circumstances:

If under age 18 and diagnosed with:

a. Both laboratory proven growth hormone deficiency or insufficiency and significant growth retardation; or

b. Substantiated Turner's Syndrome, Prader-Willi Syndrome, or Noonan's Syndrome with significant growth retardation; or

c. Chronic renal insufficiency and end stage renal disease with significant growth retardation prior to successful transplantation; or

d. Panhypopituitarism; or

e. Neonatal hypoglycemia related to growth hormone deficiency.

If age 18 and over with:

a. Evidence of pituitary or hypothalamic disease or injury and laboratory proven growth hormone deficiency; or

b. A history of prior growth hormone therapy for growth hormone deficiency or insufficiency in childhood and laboratory confirmation of continued growth hormone deficiency.

Children, Adolescents and Adults:

a. AIDS wasting syndrome

b. Short bowel syndrome

c. Severe burn patients

5. Diabetic Supplies and Insulin

6. Oral Anticancer Medication used to kill or slow the growth of cancerous cells. Such medication is covered at 100 percent of the allowable charge.

7. Psychotherapeutic drugs used for the treatment of Mental Illness and Substance Use Disorders under terms and conditions not less favorable than coverage provided for other Prescription Drugs.

8. Generic oral contraceptives will be covered at 100%.

9. Off-label Prescription Drugs used for the treatment of cancer.

E. Payment of Benefits

Subject to the payment provisions of this Prescription Drug Program, benefits are based on the following allowable charges:

1. **Contracting Pharmacies** -- The allowable charge for a covered Prescription Drug is established under the applicable network participation agreement. The allowable charge minus the Copayment will be paid directly to the Pharmacy.

2. **Non-Contracting Pharmacies** -- The allowable charge is the lesser of the Pharmacy's actual charge for the covered Prescription Drug or the allowable charge had the order been filled by a Contracting Pharmacy. You are responsible for the Copayment and any difference between the actual charge and the allowable charge.

Benefits will be paid to the Insured. Such benefits are personal to that Insured and cannot be assigned to any other person or entity.

NOTE: If You obtain a Prescription Drug from a Contracting Pharmacy and do not, at that time, notify the Pharmacy that You are eligible for Prescription Drug benefits through this Program the Prescription will be considered as having been provided by a Non-Contracting Pharmacy.

F. Exclusions

Benefits are not provided for:

1. Prescription Drugs for which normally (in professional practice) there is no charge.

2. Prescription Drugs for other than human use.

3. Orthopedic or prosthetic appliances and devices.

4. Prescription Drugs purchased from an institutional pharmacy for use while the Insured is an Inpatient in that institution.

5. Charges for delivering any drugs.
6. Any drug prescribed or dispensed in a manner that does not agree with generally accepted medical or pharmaceutical practices.
7. Drugs, supplies, and equipment used in intravenous treatment.
8. Benefits are not available to the extent a Prescription Drug has been covered under another contract, certificate, or rider issued by Blue Cross and Blue Shield of Kansas.
9. Allergy antigens.
10. Any food item, including breast milk, formulas and other nutritional products.
11. Total parenteral nutrition.
12. Drugs available over-the-counter in the equivalent dose which do not require a Prescription Order under federal or state law except those covered under the Preventive Health Benefits section.
13. Charges for services that are not listed as covered services.
14. Services for injuries or diseases related to Your employment to the extent You are covered or are required to be covered by a worker's compensation law. If You enter into a settlement giving up Your right to recover past or future medical benefits under a worker's compensation law, the Company will not pay past or future medical benefits that are the subject of or related to that settlement.

    In addition, if You are covered by a worker's compensation program which limits benefits when other than specified providers are used, and You receive services from a provider not specified by the program, the Company will not pay balances of charges from such non-specified providers after Your benefits under the program are exhausted.
15. Services in which duplicate benefits are available under federal, state, local laws, regulations or programs. Examples of such programs are: Medicare; TRICARE; services in any veteran's facility when the services are eligible for coverage by the government. This Certificate will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid.

    This exclusion applies whether or not You choose to waive Your rights to these services except for those services that would be eligible for benefits under Medicare Part D prescription drug coverage. Such benefits shall only be excluded if You are enrolled in Part D.
16. Any service provided through a district pursuant to an Individual Education Plan (IEP) as required under any federal or state law. This exclusion applies whether or not You choose to waive Your rights to these services.
17. Health services associated with accidental bodily injuries arising from a motor vehicle accident to the extent such services are payable under medical expense payment provision of any automobile insurance policy.
18. Services not prescribed by a Doctor or continued after a Doctor has advised that further care is not necessary.
19. Services that are not Medically Necessary, as defined in this Certificate.
20. Prescription Drugs utilized primarily for stimulation of hair growth. This exclusion applies even if the drug is prescribed for purposes other than the stimulation of hair growth.
21. Charges for completion of insurance claim forms.
22. Any drug, device or medical treatment or procedure and related services that are, as of the date of service, Experimental or Investigational as defined in the General Definitions section. This exclusion does not apply to routine patient care services (as defined in Kansas Administrative Regulation 40-4-43) provided in an approved cancer clinical trial for which benefits would otherwise be available for the same services when not provided in connection with such clinical trial.
23. Services provided directly for or relative to diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion, or aggression.
24. Any drug or supply associated with the medical management and treatment of obesity. This includes, but is not limited to, nutrients and Prescription Drugs prescribed for purposes other than the treatment of obesity.
25. Appetite suppressants.
26. Any service or supply provided or obtained relative to an excluded service. "Provided relative to" refers to any service or supply which would not have been provided or obtained if the excluded service would

not have been provided and which is provided on whether an Inpatient or Outpatient basis by any Eligible Provider.

27. Growth hormone therapy or other drugs used to treat growth failure except in those situations specifically set out as eligible for benefits.
28. Certain Prescription Drugs that have therapeutically equivalent or interchangeable drugs that are available over the counter (OTC) and may be obtained without a Prescription Order. This would include drug products from the same therapeutic class containing different chemical entities, but which would provide similar effects or the same pharmacological action when administered in therapeutically equivalent doses. These drugs are listed on the Formulary.
29. Prescription Drugs listed as excluded on the Formulary. Such exclusions are in addition to drugs or classes of drugs excluded under other provisions of this Certificate.

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MAIL ORDER PRESCRIPTION DRUG PROGRAM

A. General

The Company has contracted with a Mail Order Pharmacy to make available to eligible Insureds, Prescription Drugs subject to the provisions of this Mail Order Prescription Drug Program. The benefits specified in this Mail Order Prescription Drug Program are only applicable to Prescription Drugs ordered through the Mail Order Pharmacy. Nothing in this Mail Order Prescription Drug Program requires You to utilize the Mail Order Pharmacy when filling an order for a Prescription Drug.

NOTE: All products may not be available from the Mail Order Pharmacy. The Mail Order Pharmacy may determine that certain Prescription Drugs will not be dispensed by the Mail Order Pharmacy when the product cannot be safely delivered to the Insured's home, the product is not available to the Pharmacy or the product is not commercially available.

B. Definitions

1. **Brand** means a Prescription Drug that is or has been marketed under patent protection.
2. **Compound** means a Prescription Drug: a) that is manufactured by a Pharmacy when no suitable commercial alternative is available, b) for which the main active ingredient is a covered Prescription Drug and c) for which the purpose is solely to prepare a dose form that is Medically Necessary.
3. **Copayment** means the portion of the charge for a covered Prescription Drug You are responsible for each time Your Prescription Order is filled or refilled through the Mail Order Pharmacy. . The amount of Copayment is determined by whether the order is filled with a Generic or with a Brand Drug.
4. **Diabetic Supplies** means syringes, needles, lancets, test strips and solutions, calibration strips, solutions, and insulin pump supplies used exclusively with diabetic management.
5. **Formulary** means a list of both Brand and Generic Prescription Drugs reviewed and updated by the Pharmacy Benefit Manager and Therapeutics Committee which is comprised of physicians and Pharmacists. Prescription Drugs are selected for inclusion on the Formulary based on safety, efficacy and cost effectiveness. The Formulary is subject to periodic review and modification.

   The Formulary applies only to Prescription Drugs covered under this Program. The Formulary does not apply to Inpatient medications or to medications administered by a Professional Provider. The level of benefits You receive under this Program will be affected by a Prescription Drug's Generic/Brand status on the Formulary.

   To access the Formulary, visit our website at www.bcbsks.com or call Customer Service at the telephone number listed on Your Identification Card.
6. **Generic** means a Prescription Drug that: a) is equivalent to a Brand Drug, b) is available after the patent on that Brand Drug has expired and c) is available from more than one source. Equivalent means therapeutic equivalent as determined by the U.S. Food and Drug Administration.
7. **Mail Order Pharmacy** means an establishment that is registered or licensed in the state in which it is domiciled, from which Prescription Drugs are dispensed by a Pharmacist, which has entered into a written agreement to provide Prescription Drugs to Insureds of Blue Cross and Blue Shield of Kansas who are eligible under this Program, and which has been separately identified to Insureds in a directory or through some other means. The Mail Order Pharmacy, after receiving and processing Your Prescription Order, will deliver the Prescription Drugs through a parcel delivery service company.
8. **Pharmacist** means a person registered or licensed under his or her State's laws to dispense Prescription Drugs.
9. **Pharmacy Benefit Manager (PBM)** means an entity with which Blue Cross and Blue Shield of Kansas contracts for the provision of administrative, utilization review and network services for the covered drug and supplies under this Program.
10. **Prescription Drug** means a drug approved for general use in the United States by the U.S. Food and Drug Administration, assigned a National Drug Code (NDC) number and dispensed in compliance with federal or state laws pursuant to a Prescription Order or refill.
11. **Prescription Order** means the request Your Doctor may legally issue for a Prescription Drug.
12. **Prior Authorization** is the process of obtaining approval for certain Prescription Drugs based on criteria established by the Company. Prior Authorization is required for some Prescription Drugs covered under this Program. Prescription Drugs requiring Prior Authorization are listed on the Formulary. Prescription Drugs may be added or deleted from the list on a quarterly basis.
13. **Utilization Review** means a claims review process of medical necessity. It includes the review of the medical need for prescription and quantity prescribed and the Prescription Orders to verify that Prescription Drugs were dispensed as ordered.

C. Amount of Benefits

The Copayment amounts are:

Generic Prescription Drug $37.50

Brand Formulary Prescription Drug $75.00

Brand Non-Formulary Prescription Drug $112.50

Compound Prescription Drug $112.50

Annual Out-of-Pocket Maximum: The Annual Out-of-Pocket Maximum in the Comprehensive Program section is applicable to Prescription Drug benefits. Out-of-Pocket expenses include the Deductible, Coinsurance and/or Copayment provisions under the Comprehensive Program, Prescription Drug Program and Mail Order Pharmacy Program.

D. Covered Services

Except as limited, Prescription Drugs are covered when ordered by Your Doctor for a condition You have consulted Your Doctor about, dispensed by the Mail Order Pharmacy based on a Prescription Order, and Medically Necessary.

1. The covered Prescription Drug services include:
   a. The filling of the initial Prescription Order.
   b. Refills of the Prescription Order as authorized by Your Doctor within one year from the date of the initial Prescription Order but not before at least two thirds (2/3) of the previously purchased supply has been exhausted. Authorization for an early refill to accommodate a vacation supply may be obtained by contacting the Company, but not more often than two times per Insured during any 12-month period.
   c. The reissue of a Prescription Order by Your Doctor for a medication previously ordered, but not before at least two-thirds (2/3) of the previously purchased supply has been exhausted. Authorization for an early reissue to accommodate a vacation supply may be obtained by contacting the Company, but not more often than two times per Insured during any 12-month period.
   d. **Limitations:**
      (1) The benefit for Prescription Drugs pursuant to a Prescription Order filled through the Mail Order Pharmacy shall be limited to a supply sufficient for 90 consecutive days of therapy based on criteria established by the Company.
      (2) Prior Authorization is required for some Prescription Drugs covered under this Program.
      (3) A Pharmacy is not required to fill a Prescription Order which in the Pharmacist's judgment should not be filled.
      (4) Some excluded Prescription Drugs are listed on the Formulary. These exclusions are in addition to drugs or classes of drugs excluded under other provisions of this Certificate.
2. Growth hormone therapy is covered only under one of the following circumstances:

   If under age 18 and diagnosed with:

   a. Both laboratory proven growth hormone deficiency or insufficiency and significant growth retardation; or
   b. Substantiated Turner's Syndrome, Prader-Willi Syndrome, or Noonan's Syndrome with significant growth retardation; or
   c. Chronic renal insufficiency and end stage renal disease with significant growth retardation prior to successful transplantation; or
   d. Panhypopituitarism; or
   e. Neonatal hypoglycemia related to growth hormone deficiency.

   If age 18 and over with:

   a. Evidence of pituitary or hypothalamic disease or injury and laboratory proven growth hormone deficiency; or
   b. A history of prior growth hormone therapy for growth hormone deficiency or insufficiency in childhood and laboratory confirmation of continued growth hormone deficiency.

   Children, Adolescents and Adults:

   a. AIDS wasting syndrome
   b. Short bowel syndrome
   c. Severe burn patients

3. Diabetic Supplies and Insulin
4. Oral Anticancer Medication used to kill or slow the growth of cancerous cells. Such medication is covered at 100 percent of the allowable charge.
5. Psychotherapeutic drugs used for the treatment of Mental Illness and Substance Use Disorders under terms and conditions not less favorable than coverage provided for other Prescription Drugs.
6. Generic oral contraceptives will be covered at 100%.
7. Off-label Prescription Drugs used for the treatment of cancer.

E. Payment of Benefits

Subject to the Copayment above, Your benefits are based on the following allowable charges:

Mail Order Pharmacy -- The allowable charge for a covered Prescription Drug is as provided for in the Mail Order Pharmacy Agreement.

F. Exclusions

Benefits are not provided for:

1. Prescription Drugs for which normally (in professional practice) there is no charge.
2. Prescription Drugs for other than human use.
3. Orthopedic or prosthetic appliances and devices.
4. Contraceptive devices; therapeutic devices; artificial appliances; hypodermic needles; syringes or similar devices. This exclusion applies regardless of the intended use.
5. Prescription Drugs purchased from other than the Mail Order Pharmacy which is contracting with the Company to provide Prescription Drugs to Insureds under this program. This exclusion applies only to benefits under the Mail Order Prescription Drug Program. Claims for Prescription Drugs obtained via mail order from a pharmacy other than a contracting Mail Order Pharmacy shall be subject to the benefits of the Prescription Drug Program.
6. Charges for delivering any drugs.
7. A drug approved for experimental use.
8. Any drug prescribed or dispensed in a manner that does not agree with generally accepted medical or pharmaceutical practices.
9. Drugs, supplies, and equipment used in intravenous treatment.
10. Benefits are not available to the extent a Prescription Drug has been covered under another contract, certificate, or rider issued by Blue Cross and Blue Shield of Kansas.
11. Allergy antigens.
12. Any food item including breast milk, formulas and other nutritional products.
13. Total parenteral nutrition.
14. Drugs available over-the-counter in the equivalent dose which do not require a Prescription Order by federal or state law except those covered under the Preventive Health Benefits section.
15. Charges for services that are not listed as covered services.
16. Services for injuries or diseases related to Your employment to the extent You are covered or are required to be covered by a worker's compensation law. If You enter into a settlement giving up Your right to recover past or future medical benefits under a worker's compensation law, the Company will not pay past or future medical benefits that are the subject of or related to that settlement.

    In addition, if You are covered by a worker's compensation program which limits benefits when other than specified providers are used, and You receive services from a provider not specified by the program, the Company will not pay balances of charges from such non-specified providers after Your benefits under the program are exhausted.
17. Services in which duplicate benefits are available under federal, state, local laws, regulations or programs. Examples of such programs are: Medicare; TRICARE; services in any veteran's facility when the services are eligible for coverage by the government. This Mail Order Prescription Drug Program will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid.

This exclusion applies whether or not You choose to waive Your rights to these services except for those services that would be eligible for benefits under Medicare Part D prescription drug coverage. Such benefits shall only be excluded if You are enrolled in Part D.

18. Any service provided through a district pursuant to an Individual Education Plan (IEP) as required under any federal or state law. This exclusion applies whether or not You choose to waive Your rights to these services.
19. Health services associated with accidental bodily injuries arising from a motor vehicle accident to the extent such services are payable under medical expense payment provision of any automobile insurance policy.
20. Services not prescribed by a Doctor or continued after a Doctor has advised that further care is not necessary.
21. Services that are not Medically Necessary, as defined in this Mail Order Prescription Drug Program.
22. Prescription Drugs utilized primarily for stimulation of hair growth. This exclusion applies even if the drug is prescribed for purposes other than the stimulation of hair growth.
23. Charges for completion of insurance claim forms.
24. Any drug, device or medical treatment or procedure and related services that are, as of the date of service, Experimental or Investigational as defined in the General Definitions section. This exclusion does not apply to routine patient care services (as defined in Kansas Administrative Regulation 40-4-43) provided in an approved cancer clinical trial for which benefits would otherwise be available for the same services when not provided in connection with such clinical trial.
25. Services provided directly for or relative to diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion, or aggression.
26. Any drug or supply associated with the medical management and treatment of obesity. This includes, but is not limited to, nutrients and Prescription Drugs prescribed for purposes other than the treatment of obesity.
27. Appetite suppressants.
28. Any service or supply provided or obtained relative to an excluded service. "Provided relative to" refers to any service or supply which would not have been provided or obtained if the excluded service would not have been provided and which is provided on either an Inpatient or Outpatient basis by any Eligible Provider.
29. Growth hormone therapy or other drugs used to treat growth failure except in those situations specifically set out as eligible for benefits.
30. Certain Prescription Drugs that have therapeutically equivalent or interchangeable drugs that are available over the counter (OTC) and may be obtained without a Prescription Order. This would include drug products from the same therapeutic class containing different chemical entities, but which would provide similar effects or the same pharmacological action when administered in therapeutically equivalent doses. These drugs are listed on the Formulary.
31. Prescription Drugs listed as excluded on the Formulary. Such exclusions are in addition to drugs or classes of drugs excluded under other provisions of this Certificate.
32. Specialty Prescription Drugs.

ALLOWABLE CHARGES

This Section will tell You what the allowable charge for a service is. It may or may not be the same as the actual charge. Inclusion of a service or provider type in the Allowable Charges section below does not imply coverage for such service. See Covered Services to determine the extent of Your coverage.

As used herein, actual charge means the total amount billed by a provider to all parties for a particular service.

A. Contracting Providers of Blue Cross and Blue Shield of Kansas for other than Prescription Drugs or Sleep Studies.

The Contracting Provider Agreement between the provider and the Company sets out the method the Company will use to determine allowable charges for covered services. Contracting Providers have agreed to accept the Company's determination of Your benefits as payment in full for covered services, except that You are responsible for payment of: Deductible, Coinsurance, Copayment/Copay amounts, shared payment amounts, non-covered services, private room charges in excess of the allowable amount stated in Your Certificate, and amounts in excess of any other benefit limitations of Your Certificate.

B. Contracting Providers of Blue Cross and Blue Shield of Kansas for limited services for other than Prescription Drugs or Sleep Studies.

In certain situations, Institutional Providers may be Contracting Providers for only a limited set of services, e.g., chemical dependency treatment or Outpatient treatment of Medical Emergencies and Accidental Injuries. In such cases, such an Institutional Provider will be treated as a Contracting Provider for the purpose of acceptance of allowable charges established by the Company as payment in full, and direct payment of benefits. For services other than the limited set of services identified above, these Institutional Providers will be considered Non-Contracting.

C. Prescription Drugs

The allowable charge is the amount that contracting providers of the Company's Pharmacy Benefit Manager have agreed to as payment in full for covered Prescription Drugs and/or supplies except that You are responsible for payment of any Deductible, Coinsurance or Copayment/Copay amounts.

D. Contracting Providers of Sleep Studies.

1. **Sleep Studies provided within the Company Service Area:**

   a. **Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of Blue Cross and Blue Shield of Kansas that are Accredited by the American Academy of Sleep Medicine (AASM) and/or the Accreditation Commission for Health Care, Inc. (ACHC) and the physicians to be board certified in sleep medicine.**

   The Contracting Provider Agreement between the provider and the Company sets out the method the Company will use to determine allowable charges for covered services. Contracting Providers have agreed to accept the Company's determination of Your benefits as payment in full for covered services, except that You are responsible for payment of: Deductible, Coinsurance, Copayment/Copay amounts, shared payment amounts, non-covered services, private room charges in excess of the allowable amount stated in Your Certificate, and amounts in excess of any other benefit limitations of Your Certificate.

   b. **Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of Blue Cross and Blue Shield of Kansas that are Not Accredited by the American Academy of Sleep Medicine (AASM) and/or the Accreditation Commission for Health Care, Inc. (ACHC) and the physicians to be board certified in sleep medicine.**

   The allowable charge will be the actual charge for covered services up to 60% of the maximum amount allowable to a Contracting Provider that is accredited by the American Academy of Sleep Medicine or Board Certified in Sleep Medicine. Contracting Providers have agreed to accept the Company's determination of Your benefits as payment in full for covered services, except that You are responsible for payment of: Deductible, Coinsurance, Copayment/Copay amounts, shared payment amounts, non-covered services, private room charges in excess of the allowable amount stated in Your Certificate, and amounts in excess of any other benefit limitations of Your Certificate.

2. **Sleep Studies provided outside the Company Service Area:**

   a. **Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Accredited by the American Academy of Sleep Medicine (AASM) and/or the Accreditation Commission for Health Care, Inc. (ACHC) and the physicians to be board certified in sleep medicine.**

   The allowable charge will be the actual charge up to the maximum amount allowable as determined as described in item F.2.a. below.

b. **Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Not Accredited by the American Academy of Sleep Medicine (AASM) and/or the Accreditation Commission for Health Care, Inc. (ACHC) and the physicians to be board certified in sleep medicine.**

The allowable charge will be the actual charge for covered services up to 60% of the maximum amount allowable as determined in F.2.a. below. You will be responsible for the difference between the allowable charge and the maximum amount allowable as determined in item D.2.a. above.

E. Non-Contracting Providers

If You receive services from a provider who has not contracted with Blue Cross and Blue Shield of Kansas or another Blue Cross and Blue Shield Company (for services provided outside the Company Service Area), the allowable charges (before application of any Deductible, Coinsurance, Copayment/Copay, shared payment or benefit limits called for by Your Certificate) will be determined as follows and You are responsible for any difference between the allowable charge and the actual charge. As used in this section, "Contracting" means contracting with Blue Cross and Blue Shield of Kansas.

When a covered service that is required for a Medical Emergency is provided by a Non-Contracting Provider, the allowable charge will be the actual charge for the service up to the maximum amount allowable for the same service provided by providers that are Contracting Institutional Providers of the Company that are the same kinds of providers or Contracting Professional Providers of the Company with the same licensure or certification.

"Same service" as used in this Section E shall be determined on the basis of the intended result of the service and not the technical methodology used by the provider to perform that service.

All reimbursement identified in this Section E is paid according to the cost-containment policies and procedures applicable to Contracting Providers. If You receive services from a Non-Contracting Provider, You will be responsible for payment for services for which payment is not made by the Company due to a cost-containment policy or procedure applicable to a Contracting Provider of the same licensure providing the same service. Such cost-containment policies include, but are not limited to, determinations by the Company that the services provided are of such a nature that they should be considered one service with a single payment, or that the billing for service inappropriately categorized the nature of the services performed, in the opinion of the Company, and payment should be made for a different type or different intensity of service.

1. **General Acute Care and Special Hospitals**

a. **Inpatient Services**

(1) **General Acute Care (Full-Service) Hospitals** -- The allowable charge for Inpatient services will be the lesser of:

(a) the actual charge; or

(b) 80% of the prior calendar year's average allowed charge per day (sum of allowed charges divided by sum of Inpatient days) for Contracting facilities in the same Peer Group (as designated below); or

(c) 80% of the prior calendar year's average allowed charge per day for all Contracting General Acute Care Hospitals in Kansas.

For purposes of this provision, "General Acute Care Hospitals" are defined as those Hospitals providing 24-hour emergency care, as well as a wide range of other medical services.

For purposes of this provision, "Peer Group Designations" are as follows:

Peer Group Designations

1 = Hospitals with less than 50 beds

2 = Hospitals with 51-99 beds

3 = Hospitals with more than 100 beds (excluding Topeka and Wichita)

4 = Topeka Hospitals

5 = Wichita Hospitals

(2) **Special Hospitals --** The allowable charge for Inpatient services will be the lesser of:

(a) the actual charge; or

(b) 80% of the prior calendar year's average allowed charge per day (sum of allowed charges divided by sum of Inpatient days) for all Contracting Special Hospitals of the Company.

For purposes of this provision, "Special Hospitals" are defined as those Hospitals which are primarily or exclusively engaged in the care and treatment of patients with specified medical conditions, including cardiac, orthopedic, or surgical patients.

b. **Outpatient Services** -- The Outpatient services allowable charge will be the lesser of:

(1) the actual charge; or

(2) 80% of the current year's lowest maximum amount allowable used for all Contracting Institutional Providers.

If a maximum amount allowable has not been set for services provided on an Outpatient basis, the allowable charge will be 80% of the actual charge. If no Contracting Provider provides the same service, the Company will determine an amount to be allowed for the procedure at its discretion.

2. **All Other Hospitals and Ambulatory Surgical Centers**

The allowable charge will be the lesser of:

a. the actual charge; or

b. 80% of the maximum amount allowable for a Contracting Provider for the same service.

If no Contracting Provider provides the same service, the Company will determine an amount to be allowed for the procedure at its discretion.

3. **Medical Care Facilities --** The allowable charge is the actual charge for covered services up to 80% of the maximum amount allowable for a Medical Care Facility that is a Contracting Provider.

4. **Ambulance Service --** The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable for the ambulance service had it been provided by a Contracting Provider of ambulance service under similar circumstances.

5. **Doctors of Medicine, Doctors of Osteopathy, Dentists, Optometrist, Chiropractors, Podiatrists or Certified Psychologists --** The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable for the same procedure by providers that are Contracting Providers of the Company with the same licensure or certification. If no Contracting Providers provide the same service, the Company will determine an amount to be allowed for the procedure.

6. **Private Duty Nursing, Home Health Care, Hospice, Medical Supplies, Orthopedic Appliances, Prostheses, and Other Services that may be covered by Your Certificate --** The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable for the same service by providers that are Contracting Providers of the Company with the same licensure or certification.

7. **Sleep Studies**

a. **Sleep Studies provided within the Company Service Area:**

1. **Non-Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of Blue Cross and Blue Shield of Kansas that are Accredited by the American Academy of Sleep Medicine (AASM) or Non-Contracting Professional Providers of Blue Cross and Blue Shield of Kansas that are Board Certified in Sleep Medicine**

The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable as determined in item D.1.a. above.

2. **Non-Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of Blue Cross and Blue Shield of Kansas that are Not Accredited by the American Academy of Sleep Medicine (AASM) or Non-Contracting Professional Providers of Blue Cross and Blue Shield of Kansas that are Not Board Certified in Sleep Medicine**

The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable as determined in item D.1.b. above.

b. **Sleep Studies provided outside the Company Service Area:**

1. **Non-Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Accredited by the American Academy of Sleep Medicine (AASM) or Non-Contracting Professional Providers of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Board Certified in Sleep Medicine**

The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable as determined in item D.2.a. above.

2. **Non-Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Not Accredited by the American Academy of Sleep Medicine (AASM) or Non-Contracting Professional Providers of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Not Board Certified in Sleep Medicine**

   The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable as determined in item D.2.b. above.

8. **Dentists**

   a. **Dental Services provided within the Company Service Area:**

   The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable for the same procedure by dentists that are Contracting Providers of the Company with the same licensure or certification. If no Contracting Providers provide the same service, the Company will determine an amount to be allowed for the procedure in its discretion.

   b. **Dental Services provided outside the Company Service Area:**

   The allowable charge is the smaller of: the actual charge for the service or the maximum allowable charge for the service as determined by the Company.

F. Out-of-Area Services

1. **In areas where the Company offers contracting provider status directly or through arrangements to a class or classes of providers (such as Hospitals and/or physicians):**

   a. When a provider in such class contracts with the Company, the provisions in Section A apply.

   b. When a provider in such class does not contract with the Company, the provisions in Section E apply.

2. **For out-of-area arrangements other than those set forth in item F. 1:**

   Blue Cross and Blue Shield of Kansas has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever You obtain healthcare services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees.

   Typically, when accessing care outside our service area, You will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, You may obtain care from non-participating healthcare providers. Our payment practices in both instances are described or referenced below.

   a. **BlueCard Program (not applicable to Sleep Studies and Dental Services not associated with Accidental Injuries)**

   Under the BlueCard Program, when You access covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

   Whenever You access covered healthcare services outside our service area and the claim is processed through the BlueCard Program, the amount You pay for covered healthcare services is calculated based on the lower of:

   - The billed covered charges for Your covered services; or
   - The negotiated price that the Host Blue makes available to us.

   Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with Your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

   Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for Your claim because they will not be applied retroactively to claims already paid.

   Federal law or laws of a small number of states may require the Host Blue to add a surcharge to Your calculation. If any federal law or the state laws mandate other liability calculation methods, including a

surcharge, we would then calculate Your liability for any covered healthcare services according to applicable law.

If You receive covered healthcare services under a Value-Based Program inside a Host Blue's service area, You will not bear any portion of provider incentives, risk sharing, and/or care coordination fees of such arrangement, except when a Host Blue passes those fees to us through average pricing, or fee schedule incentive adjustments. Value-Based Program means an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality factors and is reflected in provider payment.

b. **Non-Participating Healthcare Providers Outside the Blue Cross and Blue Shield of Kansas Service Area - See Section E, Non-Contracting Providers, above.**

GENERAL EXCLUSIONS

The following General Exclusions apply to all Your coverages described in this Certificate. Additional limitations and exclusions that apply to specific benefits may be found within the description of such benefits.

A. Benefits will not be provided for:

1. Services that are not listed as covered services.
2. Services for injuries or diseases related to Your employment to the extent You are covered or are required to be covered by a worker's compensation law. If You enter into a settlement giving up Your right to recover past or future medical benefits under a worker's compensation law, the Company will not pay past or future medical benefits that are the subject of or related to that settlement.

   In addition, if You are covered by a worker's compensation program which limits benefits when other than specified providers are used, and You receive services from a non-specified provider not specified by the program, the Company will not pay balances of charges from such non-specified providers after Your benefits under the program are exhausted.
3. Services in which duplicate benefits are available under federal, state, or local laws, regulations or programs. Examples of such programs are: Medicare; TRICARE; services in any veteran's facility when the services are eligible for coverage by the government. This Certificate will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid.

   This exclusion applies whether or not You choose to waive Your rights to these services except for those services that would be eligible for benefits under Medicare Part D prescription drug coverage. Such benefits shall only be excluded if You are enrolled in Part D. Waiving Your rights to these services shall include failure to purchase coverage under any such government programs, including Medicare Parts A and B, when You are eligible to purchase such coverage.
4. Any service provided through a school district pursuant to an Individual Education Plan (IEP) as required under any federal or state law.

   This exclusion applies whether or not You choose to waive Your rights to these services.
5. Services not prescribed by a Doctor or continued after a Doctor has advised that further care is not necessary.
6. Services that are not Medically Necessary, as defined in the Certificate.
7. Services that are determined not to be medically necessary through the hospital's Utilization Review process. In the absence of a hospital Utilization Review process, the Company has the right to determine when services are medically unnecessary.
8. Services provided by Institutional and Professional Providers for unnecessary Inpatient admissions when services and evaluations that could satisfactorily be provided on an Outpatient basis.
9. Any drug, device or medical treatment or procedure and related services that are, as of the date of service, Experimental or Investigational as defined in the General Definitions section. This exclusion does not apply to routine patient care services (as defined in Kansas Administrative Regulation 40-4-43) provided in an approved cancer clinical trial for which benefits would otherwise be available for the same services when not provided in connection with such clinical trial.
10. Procedures and diagnostic tests that are considered to be obsolete by the Company's professional medical-advisory committee.
11. Services provided directly for or relative to diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion, or aggression.
12. Services that are already covered under another provision of this Certificate.
13. Blood or payment to blood donors.
14. Any service or supply associated with the medical management and treatment of obesity. This includes but is not limited to surgery, office visits, hospitalizations, laboratory or radiology services, prescription drugs, medical weight reduction programs, nutrients and diet counseling except for those services covered as Preventive Health Benefits.
15. Inpatient Skilled Care, Intermediate Care, Convalescent Care, Custodial/Maintenance Care or Rest Cures.
16. All services associated with transplant procedures except those specifically set out as benefits.

17. Services associated with any mass screening type of physical or health examination except for pap smears and mammograms performed at a mobile facility certified by the Centers for Medicare and Medicaid Services. Two examples of mass screenings are mobile vans and school testing programs.
18. Autogenic biofeedback services and materials except for urinary incontinence in adults 18 years old and older.
19. Acupuncture.
20. Services or supplies associated with sex changes/gender reassignment, and services related to sexual function, and any related complications.
21. Reversal of sterilization procedures.
22. In vitro fertilization, in vivo fertilization or any other medically-aided insemination procedure.
23. Charges for autopsies, unless the autopsy is requested by Blue Cross and Blue Shield of Kansas.
24. Transportation other than covered Ambulance Services.
25. Charges for completion of insurance claim forms.
26. Laboratory services performed by an independent laboratory that is not approved by Medicare.
27. Prescription drugs utilized primarily for stimulation of hair growth. This exclusion applies even if the drug is prescribed for purposes other than the stimulation of hair growth.
28. Cosmetic or reconstructive surgery except when the surgical procedure is one of the following:
    a. Cosmetic or reconstructive repair of an Accidental Injury.
    b. Reconstructive breast surgery in connection with a Medically Necessary mastectomy that resulted from a medical illness or injury. This includes reconstructive surgery on a breast on which a mastectomy was not performed in order to produce a symmetrical appearance.
    c. Repair of congenital abnormalities and hereditary complications or conditions, limited to:
        (1) Cleft lip or palate.
        (2) Birthmarks on head or neck.
        (3) Webbed fingers or toes.
        (4) Supernumerary fingers or toes.
    d. Reconstructive services performed on structures of the body to improve/restore impairments of bodily function resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

    For purposes of this provision, the term "cosmetic" means procedures and related services performed to reshape structures of the body in order to alter the individual's appearance.
29. Refractive procedures including; radial keratotomies, corneal relaxation, keratophakia, keratomileusis, or any other procedure used to reshape the corneal curvature except for Medically Necessary procedures associated with severe anisometropia.
30. All services associated with Temporomandibular Joint Dysfunction Syndrome except those services specifically set out as benefits.
31. Health services associated with accidental bodily injuries arising from a motor vehicle accident to the extent such services are payable under a medical expense payment provision of any automobile insurance policy. The excluded expenses cannot be used for any purpose under this Certificate.
32. Automatic external defibrillators.
33. Institutional Provider services for personal items such as television, radio, telephone, comfort kits, materials used in occupational therapy, air conditioning provided on an optional basis, or internet access.
34. Professional Provider services or charges for:
    a. Services where the Provider would normally make no charge.
    b. Travel expenses, mileage, time spent traveling, telephone calls, charges for services provided over the telephone, services provided through e-mail or electronic communications. For the purpose of this provision electronic communications means communication other than telemedicine. Telemedicine means the use of telecommunications technology to provide, enhance, or expedite health care services, as by accessing off-site databases, linking clinics or physicians' offices to central hospitals, or transmitting x-rays or other diagnostic images for examination at another site.

c. Services by an immediate relative or member of Your household. "Immediate relative" means the husband or wife, children, parents, brother, sister, or legal guardian of the person who received the service. "Member of Your household" means anyone who lives in the same household and who was claimed by You as a tax deduction for the year during which the service was provided.

d. Repair or replacement of dental plates and all dental care other than that listed as a covered service.

e. Hearing aids; servicing of visual corrective devices, or consultations related to such services; orthoptic and visual training.

35. Any service associated with dental implants, surgical treatment or diagnostic services except as otherwise stated in this Certificate.

36. Educational benefits except for those pertaining to diabetic education, colostomy care, wound care, IV therapy, or any other condition or treatment which the Company has determined is appropriate for home care education.

37. Dental appliances or restorations necessary to increase vertical dimensions or restore the occlusion.

38. Any food item including breast milk, formulas and other nutritional products.

39. Appetite suppressants.

40. Drugs which are available in an equivalent dose over-the-counter and which do not require a Prescription Order by federal or state law.

41. Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders IV(1994) which are not attributable to a mental disorder and are a focus of clinical attention, e.g., marriage counseling. This exclusion applies to all benefits provided by this Certificate; it is not limited to those benefits listed for Mental Illness or Substance Use Disorders.

42. Any service or supply provided or obtained relative to an excluded service. "Provided relative to" refers to any service or supply which would not have been provided or obtained if the excluded service would not have been provided and which is provided on either an Inpatient or Outpatient basis by any Eligible Provider.

43. Diagnostic tests and evaluations are ordered, requested or performed solely for the purpose of resolving issues in the context of legal proceedings, including those concerning custody, visitation, termination of parental rights, civil damages or criminal actions.

44. Services, appliances or restorations for altering vertical dimension for restoring occlusion, for replacing tooth structure lost by attrition or abrasion, bruxism, erosion or abfractions; for aesthetic purposes; splinting or equilibration.

45. Temporary or Provisional dental services and procedures, including, but not limited to, Provisional crowns, Provisional splinting, interim complete or partial dentures. "Provisional" means a service or procedure that is provided for temporary purposes or is used over a limited period; a temporary or interim solution; usually refers to a prosthesis or individual tooth restoration.

46. Dental services and prosthodontic devices that are duplicated in whole or in part, due to the Insured failing to complete the initial treatment plan.

47. Pharmacological agent(s) inserted into a periodontal pocket to suppress pathogenic microbiota.

48. Any device used for enhancing or enabling communication except for an electrolarynx.

49. Services provided for a Mental Illness or Substance Use Disorder by a provider that is not an Eligible Provider for Mental Illness or Substance Use Disorders.

50. Non medical services (including but not limited to legal services, social rehabilitation, educational services, vocational rehabilitation, job placement services).

51. Services of volunteers.

52. Any assessment to attend an alcohol and drug safety action program by a diversion agreement or by court order.

53. Prostheses that require surgical insertion into the body and are billed by an entity or person that is not the Hospital or Ambulatory Surgical Center where the surgery was performed.

54. Services for or related to elective abortions.

For purposes of this provision, "elective" means as follows: for any reason other than to prevent the death of the mother upon whom such services are performed, except that it includes those services based on a claim or diagnosis that the mother shall or may engage in conduct likely to result in her death.

For the purpose of this provision, "abortion" means as follows: the use or prescription of any instrument, medicine, drug, or any other substance or device to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of a child after live birth, or to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma, or physical assault on the pregnant woman or her unborn child and which causes the premature termination of the pregnancy.

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APPEAL PROCEDURES

A. Purpose. This section outlines the procedures for and the time periods applicable to Claim and Appeal determination decisions for Adverse Decisions. It is the policy of the Company to afford Insureds a full and fair review of Claim decisions and Appeal decisions as a right under applicable federal and state law.

However, an Insured's rights accrued hereunder or under applicable state or federal law (including but not limited to ERISA) are not assignable to any person or entity. Authorized Representatives may be designated as provided in Section B below.

B. Definitions. For the purpose of this Appeal Procedures Section, the following terms and their definitions apply:

1. **Adverse Decision,** for the purposes of these Appeals procedures (and ERISA, as applicable), means a denial in whole or in part of a Pre-Service Claim or a Post-Service Claim and for which You are financially responsible or, for a Pre-Service Claim, for which You would be financially responsible, if You obtained the service. Adverse Decision, for the purposes of External Review procedures, is limited to the definition of Adverse Decision Eligible for External Review. Adverse Decision also means any retroactive cancellation of coverage other than for non-payment of premium.
2. **Adverse Decision Eligible for External Review** means (1) in the case of other than an Emergency Medical Condition, a Claim for a proposed or delivered health care service which would otherwise be covered under this Certificate but for which the Insured has received an Adverse Decision following an Appeal due to the fact that the service is not or was not Medically Necessary or the health care treatment has been determined by the Company to be Experimental or Investigational and the denial leaves the Insured with a financial obligation or prevents the Insured from receiving the requested service, or (2) in the case of an Emergency Medical Condition, a Claim for which an initial Adverse Decision by the Company that a proposed health care service which would otherwise be covered under this Certificate is not Medically Necessary or the health care treatment has been determined by the Company to be Experimental or Investigational and the denial would leave the Insured with a financial obligation or prevents the Insured from receiving the requested service, or (3) a Pre-Service Request for a benefit determination or advance approval a) that is not a Pre-Service Claim; b) which is denied by the Company due to the fact the requested services are not Medically Necessary or are Experimental or Investigational; and c) based upon which You choose not to obtain the requested services. For item (3) above, no Appeals need be submitted to the Company in order for the Adverse Decision to be eligible for External Review. For items (1) and (2) above, the procedure in section D. below applies. Notwithstanding any provision of this Certificate to the contrary, the External Review procedure is not available for dental services.
3. **Appeal** means a written request, except in the case of Urgent Care in which case the request may be submitted orally or in writing, for review of an Adverse Decision that is submitted to the Company by an Insured or the Insured's Authorized Representative.
4. **Authorized Representative** means, for non-urgent care, a person designated by You in writing as authorized to represent them for Appeals as permitted under ERISA. This may only be achieved through use of a form provided by BCBSKS by contacting the Customer Service Center at the telephone number on the back of Your identification card. Any attempt to designate via any other form shall be deemed void and ineffective on its face. For Urgent Care, such written authorization is not required if the Appeal is made on Your behalf by a health care provider with knowledge of Your medical condition.
5. **Claim for Benefits or Claim** means a request for treatment benefit or payment benefits made by an Insured in accordance with the Company's procedure for filing Claims. A Claim includes both Pre-Service Claims and Post-Service Claims. A Claim must have sufficient information upon which to base a decision regarding benefits according to all of the provisions of the Certificate.
6. **Emergency Medical Condition** means:
   a. The sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part or would place a person's health in serious jeopardy;
   b. a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the Insured or would jeopardize the Insured's ability to regain maximum function; or
   c. a medical condition for which coverage has been denied based on a determination that the recommended or requested health care service or treatment is experimental or investigational, if the Insured's treating physician certifies, in writing, that the recommended or requested health care service or treatment for the medical condition would be significantly less effective if not promptly initiated.
7. **ERISA** means the Employee Retirement Income Security Act of 1974. ERISA is a federal law that applies to employer sponsored health benefit plans if the employer is not a government entity or a church organization.

8. **External Review** means the review of an Adverse Decision by an External Review Organization.
9. **External Review Organization** means an entity that conducts independent External Reviews of Adverse Decisions pursuant to a contract with the Kansas Insurance Department.
10. **Pre-Service Claim** means a request for a Claims decision when prior authorization of the services is required by the Company.
11. **Pre-Service Request** means a request for advance information on the Company's possible coverage of items or services or advance approval of covered items or services that do not constitute Pre-Service Claims. Subsequent inquiries regarding the same service or item shall not be considered a Pre-Service Request unless additional substantive clinical information is provided.
12. **Post-Service Claim** means a request for a Claims decision for services that have been provided.
13. **Urgent Care** means care for a condition that delay in receiving such care could seriously jeopardize the life or health of the Insured or the ability of the Insured to regain maximum function or, in the opinion of a physician knowledgeable of the Insured's condition, would subject the Insured to severe pain that could not be adequately managed without care or treatment. In determining whether a Claim involves Urgent Care, the Company must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a physician with knowledge of the Insured's medical condition determines that a Claim involves Urgent Care, the claim must be treated as an Urgent Care Claim.

C. Initial Claim Decisions

The time periods in which the Company must make initial Claim decisions (the first determination of benefits available for an Urgent Care Claim, a Pre-Service Claim or a Post-Service Claim) are as follows:

Action	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Initial Benefit Decision (from the date the Claim is received by the Company)	72 hours	15 days	30 days
Extension (from the date the Claim is received by the Company)	None - Notice requesting additional information due - 24 hours*	30 days*	45 days*

* The time periods listed are those required. An Insured may voluntarily agree to provide the Company additional time within which to make a decision.

Time for Insured to Provide more Information (from the date the information was requested by the Company)	48 hours	45 days	45 days

D. Appeal of Initial Adverse Decisions (including Adverse Decisions Eligible for External Review)

An Insured or the Insured's Authorized Representative has the right to obtain, without charge, copies of documents relating to the Adverse Decision and has the right to appeal an Adverse Decision from an initial Claim decision. This is a first level Appeal.

1. The time periods that apply to first level Appeal decisions are as follows:

Action	Urgent Care Claim	Pre-Service Claim	Post-Service Claim Retroactive Cancellation
Time to File Appeal (from the date of receipt of the Adverse Decision)	180 days	180 days	180 days
Initial Appeal Decision (from the date the Appeal is received by the Company)	72 hours	15 days	30 days
Extension	None*	None*	None*

(from the date the Appeal is received by the Company)

* The time periods listed are those required. An Insured may voluntarily agree to provide the Company additional time within which to make a decision.

2. A first level Appeal will be coordinated by a representative of the Company's Customer Service Center.

E. Procedure for Pursuing an External Review

1. The Insured has the right to request an External Review of an Adverse Decision Eligible for External Review after an Appeal (where applicable) has been completed or when the Insured has not received a final Adverse Decision within 60 days of seeking such review, unless the delay was requested by the Insured. In the case of a request for an External Review of an Adverse Decision Eligible for External Review involving an Emergency Medical Condition, such request may be made before the Insured has exhausted all the other available review procedures. The Company will notify the Insured in writing regarding a final Adverse Decision and of the opportunity to request an External Review.

2. Within four (4) months of receipt of the notice of a final Adverse Decision, the Insured, the treating physician or health care provider acting on behalf of the Insured with written authorization from the Insured, or a legally authorized designee of the Insured must make a written request for an External Review to the Kansas Insurance Commissioner, at the Kansas Insurance Department, 420 SW 9th Street, Topeka, KS 66612, (785) 296-3071 or (800) 432-2484.

3. Within ten (10) business days of receipt of such request (immediately, when the request for External Review involves an Emergency Medical Condition), the Kansas Insurance Commissioner will notify the Insured and other involved parties as to whether the request for External Review is granted.

4. For those requests that qualify for External Review, the External Review Organization will issue a written decision to the Insured and the Kansas Insurance Commissioner within 30 business days. The External Review Organization will issue its written decision within 72 hours when the request for External Review involves an Emergency Medical Condition. The standard of review shall be whether the health care service denied by the Company was Medically Necessary or in the case of reviews regarding Experimental or Investigational treatment, whether the health care service denied by the Company was covered or excluded from coverage under the terms of this Certificate.

5. The decision of the External Review Organization may be reviewed directly by the district court at the request of either the Insured, insurer, or health insurance plan. The review by the district court shall be de novo. The decision of the External Review Organization shall not preclude the Insured, insurer or health insurance plan from exercising other available remedies applicable under state or federal law. Seeking a review by the district court or any other available remedies exercised by the Insured, insurer or health insurance plan after the decision of the External Review Organization will not stay the External Review Organization's decision as to the payment or provision of services to be rendered during the pendency of the review by the insurer or health insurance plan. All material used in an External Review and the decision of the External Review Organization as a result of the External Review shall be deemed admissible in any subsequent litigation.

The right to External Review shall not be construed to change the terms of coverage under this Certificate. In no event shall more than one External Review be available during the same year for any request arising out of the same set of facts.

F. Right to a Judicial Review

You have the right to bring suit (including under ERISA Section 502(a) if applicable) in state or federal court (as appropriate) only after You have exhausted the first level Appeal of an Adverse Decision, whether or not You pursue External Review. However, in the case of an Adverse Decision Eligible for External Review involving an Emergency Medical Condition, no Appeal is necessary and only completion of the External Review process is required in order for the right to bring suit to accrue. In all events, such suit or proceeding must be commenced no later than 5 years after the date from the time written proof of loss is required to be given.

G. Strict Adherence by Company

If for any reason the Company fails to strictly adhere to these appeal procedures as required by state or federal law, the Insured shall be deemed to have exhausted the internal claims and appeals process regardless of whether the Company asserts it substantially complied with appeals procedures or committed any de minimis error.

GENERAL INFORMATION

A. Company's Right to Determine if Services are Medically Necessary: Benefits are available only for medically necessary services. The Company has the right to require information, including medical records, to make this decision.

B. Insured/Provider Relationship: The choice of a provider is solely that of the Insured.

C. The Company's Responsibility is Limited: Institutional Provider services are subject to the rules and regulations of the provider including rules about admissions, discharge and availability of services. The Company does not guarantee that admission or any specific type of room or kind of service will be available.

The Company is obligated to provide benefits for the services of Your Eligible Provider only to the extent provided in this Certificate. The Company does not guarantee the availability of a provider.

The Company shall not be liable for any acts or admissions of any provider of service. This includes negligence, misconduct, malpractice, refusal to provide a service or breach of contract.

D. Your Identification Card: When You receive services, show Your current Identification Card when obtaining services from an Eligible Provider at the provider's office.

E. Your Authorization: By accepting coverage under this Certificate, You permit the Company to request any information related to a claim for services that You received and authorize that any information may be given to the Company regarding medical services You have received. This applies to all types of claims, including claims related to Medicare.

If the Company asks for information and does not receive it, payment for covered services cannot be made. The claim will be processed for payment only when the requested information has been received and reviewed.

F. Notice of Claim: You are responsible for submitting written notice of claim within 20 days after a covered loss begins or as soon as reasonably possible. If Your provider submits written notice on Your behalf within the time period specified above, such notice will satisfy the requirements of this provision. The notice can be given to Blue Cross and Blue Shield of Kansas at its home office, 1133 SW Topeka Boulevard, Topeka, Kansas 66629. Notice should include Your name and Your identification number as stated on Your Identification Card.

G. Claim Forms: The Company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice the claimant shall be deemed to have complied with the claim filing requirements of Your Certificate.

H. Proof of Loss: Written proof of loss must be furnished to the Company at 1133 SW Topeka Boulevard, Topeka, Kansas 66629, in case of claim for loss for which Your Certificate provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the Company is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

I. Time of Payment of Claims: Benefits payable under Your Certificate will be paid immediately upon receipt of proper written proof of loss.

J. Payment of Claims. For covered services received from the following providers:

1. **Contracting Provider of Blue Cross and Blue Shield of Kansas or another entity on behalf of Blue Cross and Blue Shield of Kansas:** Your benefits will be paid directly to the Contracting Provider.
2. **Contracting Provider of Blue Cross and Blue Shield of Kansas for limited services:**

   When You receive services for which the provider is contracting Your benefits will be paid directly to the Contracting Provider.

   When You receive services for which the provider is not contracting Your benefits will be paid directly to You. Such benefits are personal to You and cannot be assigned to any other person or entity.
3. **Non-Contracting Provider in the Company Service Area:** Your benefits will be paid directly to You. Such benefits are personal to You and cannot be assigned to any other person or entity.
4. **Covered Provider in a class of providers that are not offered Contracting Provider status:**

   Your benefits will be paid directly to You, with such benefits being personal to You and not assignable to any other person or entity.
5. **Covered Provider Outside the Company Service Area:**

a. Located in an area where the Company offers contracting provider status, directly or through arrangements with another entity, to the provider from whom service was received:

(1) if the provider is a Contracting Provider, Your benefits will be paid to the provider.

(2) if the provider is a Non-Contracting Provider, Your benefits will be paid directly to You, with such benefits being personal to You and not assignable to any other person or entity.

b. Located in an area where the Company does not offer contracting provider status, either directly or through arrangements with another entity, to the provider from whom service was received:

(1) In instances where the Insured receives service from a provider that is contracting with the Blue Cross and/or Blue Shield Company servicing the area in which the provider is located, payment will be made directly to the provider.

(2) In instances where the Insured receives service from a provider that is not contracting with the Blue Cross and/or Blue Shield Company servicing the area in which the provider is located, Your benefits will be paid directly to You, with such benefits being personal to You and not assignable to any other person or entity.

6. Any benefits unpaid at Your death may be paid to Your estate.

If benefits are payable to Your estate, the Company may pay up to $1,000 to anyone related to You by blood or marriage, whom the Company considers to be entitled to the benefits. The Company will be discharged to the extent of any such payment made in good faith.

K. Physical Examination: The Company, at its expense, has the right to have You examined as often as reasonably necessary while a claim is pending.

L. Legal Actions: No legal action may be brought to recover on Your Certificate within 60 days after written proof of loss has been given as required by Your Certificate. No such action may be brought after 5 years from the time written proof of loss is required to be given.

M. Errors Related to Your Coverage: If the Company's records of Your coverage are in error due to a Company error or delay, the record will be corrected after discovery of the error. If Your premiums are affected, the Company may need to make a retroactive change in Your premiums. The Company will make appropriate changes in Your coverage and/or premiums to ensure that You have the coverage You are entitled to under this Certificate.

The Company has the right to correct benefit payments which are made in error. Providers and/or You have the responsibility to return any overpayments to the Company. The Company has the responsibility to make additional payments if an underpayment is made.

N. Statements Made by the Contract Holder or the Insured: A copy of the application, if any, of the Contract Holder shall be attached to the Contract when issued. All statements made by the Contract Holder or by the Insured will be deemed representations and not warranties. No statement made by an Insured will be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the Insured.

O. Notice

1. **From the Company to the Contract Holder.** A notice sent to the Contract Holder by the Company is considered given when mailed to the Contract Holder's address as it appears in the records of the Company.

2. **From the Company to an Insured.** A notice sent to an Insured by the Company is considered given when mailed to the Insured's address as it appears in the records of the Company.

3. **From the Contract Holder or an Insured to the Company.** Notice to the Company is considered given when received by the Company at 1133 SW Topeka Boulevard, Topeka, Kansas 66629. Any such notice should include the Insured's name and the identification number on the Identification Card.

P. Changes In this Contract: Benefits and premiums may be changed after approval by the Board of Directors of the Company and filing by the Kansas Insurance Commissioner.

No agent or representative of the Company other than its Board of Directors is authorized to change this Contract or waive any of its provisions.

Q. Notification of Change: The Contract Holder will be given notice of any benefit change by a new Group Contract, rider, amendment, or other means as permitted by law. If substantive changes to the Certificate issued thereunder are made, new Certificates or riders or amendments will also be issued.

R. Acceptance of Change: If premium payment is made to the Company after the effective date of any change to the Group Contract, such payment shall be deemed consent to that change.

S. Claims Recoveries

There may be circumstances in which the Company recovers amounts paid as claims expense from the provider of service, from the Insured or from a third party. Such circumstances include rebates paid to the Company by pharmaceutical manufacturers based upon amounts of claims paid by the Company for certain specified pharmaceuticals, amounts recovered by the Company from health care providers or pharmaceutical manufactures through certain legal actions instituted by the Company relating to the claims expense of more than one Insured, recoveries by the Company of overpayments made to health care providers or to Insureds, and recoveries from other parties with whom the Company contracts or otherwise relies upon for payment or pricing of claims. The following rules govern the Company's actions with respect to such recoveries:

1. In the event such recoveries relate to claims paid more than a year and 90 days before the recovery, no adjustment will be made to any Deductible or Coinsurance paid by an Insured and the Company shall be entitled to retain such recoveries for its own use. If the recovery relates to a claim paid within a year and 90 days and is not otherwise addressed herein, Deductible and Coinsurance amounts for an Insured will be adjusted for the applicable benefit period if affected by the recovery.
2. Such recoveries (except for recoveries made within a year and 90 days of the date of the error by the Company of overpayments to health care providers or to Insureds by the Company not involving assertion of a mass claim by the Company) will not be applied for the purpose of group rating or divisible surplus calculation, if applicable, in any event. The cost actually paid by the Company to procure such recoveries will be treated as an administrative expense in considering group rating or divisible surplus, if applicable. The amounts of recovery available in any event to be applied to the group claims expense will be reduced by the cost to the Company to procure that recovery, including amounts paid in attorney fees, amounts paid to collection agencies or other entities, where such entities obtain recoveries on a contingency basis.
3. In the event Blue Cross and Blue Shield of Kansas receives from pharmaceutical manufacturers rebates based upon amounts of claims paid by Blue Cross and Blue Shield of Kansas for certain specified pharmaceuticals, Blue Cross and Blue Shield of Kansas shall be entitled to retain such rebates for its own use, and no adjustments will be made to claims paid on behalf of the Contract Holder, to Deductible, Coinsurance or Copayments/Copays paid by Insureds, or to other cost-sharing or claims amounts.
4. If an Insured is no longer covered by the Company at the time any such recovery is made, regardless of the amount or of the time of such recovery, the Company shall be entitled to retain such recovery for its own use.
5. If such recovery amounts cannot be attributed on an individual basis, because of having been paid as a lump sum settlement for less than the total amount of claims expense of the Company or otherwise, no adjustments will be made to any Deductible, Coinsurance or Copayment/Copay amounts paid by the Insured and the Company shall be entitled to retain such recovery for its own use.
6. The amount of any recoveries which are otherwise available for adjustments to Deductible, Coinsurance or Copayments/Copays will be reduced by the cost to the Company to procure that recovery, including amounts paid in attorney fees, amounts paid to collection agencies or other entities obtaining recoveries on a contingency basis.
7. Under no circumstances shall such claim recoveries include subrogation.

T. For additional information regarding the benefits covered hereunder or to obtain a copy of the list of Contracting Providers that when used will assure that You are receiving the highest possible level of benefits available under Your Certificate, call the Customer Service phone number on Your Identification Card. Information You request about benefits and lists of Contracting Providers will be furnished without charge.

U. **Certificate of Creditable Coverage:** You have the right to request and obtain a Certificate of Creditable Coverage from the Company while You are an Insured and up to 24 months following the date on which Your coverage cancelled. To request a Certificate of Creditable Coverage contact the Customer Service phone number on Your Identification Card.

V. **Contract Holder's Responsibilities Concerning Enrollment:** It is the responsibility of the Contract Holder/employer group's Plan Administrator to submit to the Company for enrollment only those employees and dependents who meet the eligibility criteria of the Contract Holder and the Company, and to ensure and verify the continued eligibility status of covered employees and dependents. The Company has the right to recover from Insureds and/or providers any benefit payments paid on behalf of ineligible persons.

W. **Contract Holder's Responsibilities Concerning Federal Minimum Loss Ratio Rebates**

In the event the Company is required to provide rebates pursuant to 45 CFR 158.240 et.seq., the Contract Holder (and its member employers in the case of an association or multiple employer trust) shall be responsible for calculating the amount of each Certificate Holder's proportionate share and distributing such rebates to

Certificate Holders. Contract Holder (including on behalf of any member employers as noted above) also agrees to timely provide Company with rebate verification data required under 45 CFR 158.242 in the manner requested by the Company.

X. Choice of Law: The terms of this Certificate shall be construed solely pursuant to the taws of the state of Kansas to the extent not pre-empted by federal law.

Form GI-792 1/15

COORDINATION OF THIS GROUP CERTIFICATE'S BENEFITS WITH OTHER BENEFITS

This coordination of benefits (COB) provision applies when an Insured has health care coverage under more than one Plan. "Plan" is defined below.

The order of benefit determination rules below determines which Plan will pay as the Primary Plan. The Primary Plan that pays first pays without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all group Plans do not exceed 100% of the total allowable expense.

A. DEFINITIONS

1. A "Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate Certificates are used to provide coordinated coverage for Insureds of a group, the separate Certificates are considered parts of the same Plan and there is no COB among those separate Certificates.

   a. "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care; school accident-type coverages and governmental benefits, as permitted by law.

   b. "Plan" does not include: individual insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of $200 or less per day; group or group-type accident only coverage, benefits for non-medical components of group long-term care policies; Medicare; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law and the medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts.

   Each Certificate for coverage under a. or b. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

2. The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when compared to another Plan covering the Insured.

   When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

3. "Allowable Expense" means a health care service or expense, including deductible, coinsurance and copayment amounts, that is covered at least in part by any of the Plans covering the Insured. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an Allowable Expanse. The following are examples of expenses or services that are not Allowable Expenses.

   a. If an Insured is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the Insured's stay in a private hospital room is Medically Necessary, or one of the Plans routinely provides coverage for hospital private rooms) is not an Allowable Expense.

   b. If an Insured is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

   c. If an Insured is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, or if one Plan calculates its benefits or services on the basis of usual and customary fees and another Plan provides its benefits or services on the basis of negotiated fees, any amount in excess of the highest of the fees is not an Allowable Expense.

   d. The amount a benefit is reduced by the Primary Plan because an Insured does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

4. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which an Insured has no coverage under this Plan, or before the date this COB provision or a similar provision takes effect.

5. "Closed Panel Plan" is a Plan that provides health benefits to Insureds primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

B. ORDER OF BENEFIT DETERMINATION RULES

When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

1. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.
2. A Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
3. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
4. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

   a. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Plan is primary.

   b. Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one Plan is:

      (1) The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

      (2) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods or plan years commencing after the Plan is given notice of the court decree.

      (3) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

      - The Plan of the custodial parent;
      - The Plan of the spouse of the custodial parent;
      - The Plan of the noncustodial parent; and then
      - The Plan of the spouse of the noncustodial parent.

   c. Active or Inactive Employee. The Plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an 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 is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled B.4.a.

   d. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. 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 is ignored.

e. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is primary.

f. If the preceding rules do not determine the Primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this regulation. In addition, this Plan will not pay more than it would have paid had it been primary.

C. EFFECT ON THE BENEFITS OF THIS PLAN

1. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than 100% of total allowable expenses. The difference between the benefit payments that this Plan would have paid had it been the Primary Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this Plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this Plan will:

   a. Determine its obligation to pay or provide benefits under its contract;

   b. Determine whether a benefit reserve has been recorded for the Insured; and

   c. Determine whether there are any unpaid allowable expenses during that claims determination period.

   If there is a benefit reserve, the Secondary Plan will use the Insured's benefit reserve to pay up to 100% of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

2. If an Insured is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

D. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Company any facts it needs to apply those rules and determine benefits payable.

E. FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

F. RIGHT OF RECOVERY

If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Form ND-155 1/14

CANCELLATION

A. Cancellation of the Group Contract: The Group Contract can be canceled effective the date to which premiums have been paid, for several reasons.

Cancellation by the Company:

1. The Company may cancel the Group Contract for the following reasons:
   a. Nonpayment of premiums by the Contract Holder. The Contract Holder has a grace period of 10 days following the due date for payment of premiums. Unless premiums are received by the end of the stated grace period, coverage under this Certificate terminates as of the payment-due date.
   b. Fraud or intentional misrepresentation of a material fact by the Contract Holder, or employer.
   c. Non-compliance with provisions of this Contract.
   d. Failure to meet or maintain the participation or employer contribution requirements of the Company.
   e. The Company ceases to offer a particular type of group coverage provided the provisions of Kansas law associated with such action are met, (including but not limited to obligations to provide at least 90 days prior notice to contract holders and employers of the decision to cease to offer such coverage and the option such terminated groups have to purchase any other group coverage otherwise available from the insurer to a similarly situated group).
   f. If this Contract is issued to a small employer as defined by Kansas or federal law applicable to health insurance, the Company ceases doing business in the small employer market, provided that the provisions of Kansas law associated with such action are met, (including the obligation to provide notices at least 180 days prior to the date of the discontinuation of such coverage, to regulatory authorities, contract holders, and employers of the decision to cease to do such business, all group policies are discontinued and not renewed and the Company does not re-enter the small employer marketplace for five years from the date of notice).
   g. When there is no longer any eligible employee, member or dependent enrolled under this Contract who lives, resides or works in the Company Service Area.

   Cancellation for the foregoing reasons will be effective on the date specified by the Company in a written notice of termination.

Cancellation by the Contract Holder:

The Contract Holder may cancel the Group Contract by giving the Company 15 days advance written notice. Cancellation is effective the date to which premiums have been paid.

B. Termination of an Individual Insured's Coverage under the Group Contract: The coverage of an individual Insured will terminate in the following situations:

1. When the Company is notified that an Insured's coverage is to be removed from the group, the Insured's coverage under this Certificate will end as of the date the Insured's premiums are paid to. The Insured is not entitled to a grace period or benefits during a grace period.
2. Termination of marriage. The coverage of the husband or wife of the person named on the Identification Card ends on the last day of the month in which the divorce was granted by court action.
3. Children who no longer qualify under the general definition of "Insured".
4. Children who are age 18 or over and qualify under the general definition of "Insured" but for whom a written request to terminate coverage has been received.
5. If an Insured permits the use of their or any other Insured's Blue Cross and Blue Shield of Kansas Identification Card by any other person, or uses another Insured's card, all rights of the Insured(s) may be terminated effective immediately upon written notice.
6. If an Insured fails to disclose information requested by Blue Cross and Blue Shield of Kansas or intentionally misrepresents information provided to Blue Cross and Blue Shield of Kansas, then the rights of such Insured under this Certificate may be rescinded with a 30 days minimum written notice. At the effective date of such termination, prepayments received on account of such terminated Insured applicable to periods after the effective date of termination shall be refunded less nonrecoverable claims paid and the Company shall have no further liability or responsibility under this Certificate.
7. When an Insured is determined to be ineligible for coverage provided by this Contract Holder. All rights of the Insured may be terminated effective immediately upon written notice and coverage may be retroactively cancelled effective the first day of the month following the date on which the Insured became ineligible for coverage. At the effective date of such termination, prepayments received on account of such terminated Insured applicable to periods after the effective date of termination shall be refunded and the Company shall have no further liability or responsibility under this Certificate.

C. Reinstatement: If an Insured's coverage is canceled for non-payment of premiums by the Contract Holder (see A.1.a. above), the Company has the right to decide whether or not to reinstate the Group Contract. If coverage is reinstated, there will be no gap in coverage.

D. Benefits When Your Coverage is Canceled: Your coverage ends on the date of cancellation, except for an Insured who is receiving Inpatient Hospital services when that person's coverage terminates. In such case, benefits may be extended for that Insured without payment of premium for a period not less than 31 days following the termination date of the coverage. This extension of benefits shall be secondary to any subsequent replacement group health benefit plan or policy which is intended to provide continuous coverage.

This extension of benefits will be terminated upon the earlier of:

1. the completion of a 31 day period following termination of coverage; or
2. the date Hospital confinement ends.

E. When a grace period for payment of premiums is applicable, benefits are provided during the grace period only if premiums are received by the end of the stated grace period. The only Insureds who have a grace period are those canceled with the whole group under the nonpayment of premiums provision in subsection A.1.a. above.

Form CA-575 1/14

CONTINUED COVERAGE RIGHTS UNDER COBRA AND USERRA, CONTINUED COVERAGE UNDER KANSAS LAW AND CONVERSION

A. COBRA Continuation Coverage - Federal Law

This law applies to employers whose payroll included 20 or more employees during the previous calendar year and such employer's group health plans, not to insurance contractors or third party administrators. That is, if Your employer changes from Blue Cross and Blue Shield of Kansas to another insurance carrier or third party administrator (in the case of a self-funded arrangement), the right to continuation under federal law remains with the employer through the new carrier or to claims adjudication under the new administrator.

CONTINUOUS COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. If You have recently become covered under the group health plan of the Group Contract Holder (the Plan) or have changed to a type of coverage that includes coverage for Your spouse and/or dependent child(ren), this is the initial notice of COBRA continuation coverage rights. Otherwise, this section is included as part of this Certificate for informational purposes. This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to You when You would otherwise lose Your group health coverage. It can become available to You and to other members of Your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about Your rights and obligations under the Plan and under federal law, You should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

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 notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary" You, Your spouse, and Your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You are an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from Your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child".

If the group health plan offered by Your employer includes coverage for retired employees, 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 entity identified on the face page of this Certificate, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after Your employer's Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, for group health plans that include coverage for retired employees commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify Your employer's Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), You must notify Your employer's Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to Your employer's Plan Administrator.

How is COBRA Coverage Provided?

Once Your employer's 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 employees 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), Your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuous coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled and You notify Your employer's Plan Administrator in a timely fashion, You and Your entire family 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 continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If Your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website)

Keep Your Plan Informed of Address Changes

In order to protect Your family's rights, You should keep Your employer's Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to Your employer's Plan Administrator.

Plan Contact Information

USD 262 VALLEY CENTER
143 S Meridian Ave.
Valley Center, KS

The Company has agreed with the employer to undertake only limited duties with respect to COBRA as set forth below.

1. **Payment of Premiums**

   Upon receipt of the COBRA Declaration Form, the Company will send the employee or dependent who qualifies for COBRA continuation of benefits a notice of the amount of premiums needed for the continued benefits. A period of 45 days (from the date of election/declaration) is allowed in which to pay the initial required premiums. The first premium payment will be for a period commencing with the date following the date coverage would otherwise terminate. No gap in coverage will be permitted. The premiums may be higher than for active employees, as permitted by law.

   Subsequent premium payments will be allowed a 30-day grace period after the due date. The Company will bill the Insured directly and payment will be made directly to the Company.

2. **Enrollment and Benefit Changes**

   a. If the group changes benefits, the COBRA Insured's benefits will also change to match the group's new benefit package.

   b. The COBRA Insured has the same right to change benefit programs as the active group employees. If the active employee is allowed to change from HMO coverage to a traditional coverage during the employer's Open Enrollment period, a COBRA Insured is allowed the same opportunity. Transfers which will impose a pre-existing waiting period will not be permitted.

   c. If the employer changes insurers during the period of Continued Group Benefits, the COBRA Insured for that group will be canceled as to coverage under this Certificate and become the responsibility of the new insurer.

   d. The Company shall not be obligated to provide COBRA coverage to You if the Contract Holder or Plan Administrator fails to timely notify You of Your rights under COBRA or You fail to timely elect COBRA coverage.

3. **Conversion Privilege**

   COBRA Insureds who complete the COBRA Continuance of Benefits period are then eligible for a conversion contract offered by Blue Cross and Blue Shield of Kansas at the conversion contract rates then in effect. This conversion is only applicable to Insureds whose group offers health insurance with Blue Cross and Blue Shield of Kansas at the time the Insured's eligibility under COBRA ends. Section D describes the conversion privilege in more detail.

B. USERRA Continuation Coverage - Federal Law

USERRA applies to ALL employer groups even if COBRA does not apply to the employer.

The right to USERRA continuation coverage was created by a federal law, the Uniformed Services Employment and Re-employment Rights Act of 1994 and amendments (USERRA).

Continuation and Reinstatement of Coverage on Account of Qualified Uniformed Service. Apart from the rights to continued coverage described in the preceding information, if applicable, You may be entitled to continue certain aspects of Your coverage (on a self-pay basis) during a period of Qualified Uniformed Service. You also may have certain reinstatement rights following a period of Qualified Uniformed Service. The specific rules are as follows:

1. **Persons Eligible for Continued Coverage.** An employee who is absent from the employment of his or her employer on account of a period of Qualified Uniformed Service may continue employee and dependent medical coverage on a self-pay basis for the 24 month period beginning on the date on which the employee is first absent from employment by reason of Qualified Uniformed Service. Coverage will terminate on the day after the date on which the employee fails to apply for or return to a position of employment, if the failure to apply or return terminates the employee's right to reemployment rights under applicable federal law regarding uniformed service.

2. **Cost of Continued Coverage**. The monthly charge for continued coverage will be determined by the Company, and will be the same for all similarly situated individuals electing the same type of coverage under this provision. If any single period of Qualified Uniformed Service is for a period of less than 31 days, the only amount required to be paid by the employee is the amount, if any, the employee would pay

if he or she had not entered Qualified Uniformed Service. In other cases, the employee's charge will reflect both the employee's portion and the employer's portion, determined in the same manner as COBRA charges.

3. **Benefits Subject to Continuation.** Any election made by an employee applies to the employee and the employee's dependents who otherwise would lose coverage under this Certificate. No separate election may be made by any dependent. The medical coverage that employees are allowed to continue on behalf of themselves and their dependents will be the same as that provided to employees and their dependents under the Plan. Except in connection with circumstances that permit other employees to make changes, an employee may continue only the type of coverage that he or she was receiving on the day before the employee first was absent from employment.
4. **Election of Continued Coverage**. An employee eligible to continue coverage under this provision will be sent an application for continued coverage within 30 days after the Company receives notice, satisfactory to the Company, that the employee will be, or is, absent from employment for a period of Qualified Uniformed Service. If an employee wishes to have coverage continued, he or she must complete the application and return it to the Company within 60 days from the later of the date the application is sent or the date coverage otherwise would terminate.
5. **Payment for Continued Coverage.** The continuation of coverage is conditioned on an employee's payment of the monthly charges for the coverage, determined from the date coverage otherwise would terminate, even if the employee waits 60 days from that date to return the application. If an employee elects continued coverage, payment must be made, relating back to the date that coverage otherwise would terminate, within 45 days after the date the employee elects to continue coverage. After that, payments must be made by the first day of each month for which coverage is to be provided, subject to a 30-day grace period.
6. **Interaction with COBRA** (if applicable):

   Generally, rights to USERRA and COBRA continuation coverage run concurrently from the commencement of Qualified Uniformed Service. Accordingly, employees and/or their dependents may have continuation rights that extend beyond 24 months.
7. **Reemployment Rights**

   If Your coverage has been terminated as a result of the service member's failure to elect continuation coverage, or the service member's length of service, at the time of the service member's reemployment no exclusions or waiting period may be imposed where one would not have been imposed if the coverage of the service member had not been terminated as a result of service in the uniformed services. This provision does not apply to any condition (illness or injury) determined by the Secretary of Veterans Affairs to have been incurred or aggravated during service, however, the service member and any dependents must be reinstated as to all other medical conditions covered by this Certificate.

C. Kansas State Continuation Law

The following provisions of Kansas laws governing group health insurance benefits for hospital, surgical and medical services apply to persons who do not have a right to continue coverage under the federal law.

An employee or such person's covered dependents, whose hospital, surgical or major medical expense insurance (and dental insurance in conjunction with the aforementioned) under the Group Contract has been terminated for reasons such as discontinuance of the Group Contract in its entirety or with respect to an insured class of persons, is entitled to have such continuation coverage under the Group Contract, subject to the following provisions:

1. The employee or covered dependent must have been continuously insured under the Group Contract (or a group policy providing similar benefits which was replaced by the Group Contract) for at least three (3) months immediately prior to termination.
2. Such group benefits may be continued under the Group Contract for a period of 18 months.

   Clarification:

   A dependent whose eligibility as a dependent ceases during the 18-month period may complete the 18-month period under separate coverage.
3. Continuation of group benefits does not apply:
   a. Where persons are on continuation coverage and during that 18-month period the Group Contract is replaced. Such persons for that group will be canceled as to coverage under this Contract and become the responsibility of the new insurer.
   b. When termination of coverage under the Group Contract occurs because any employee failed to pay any required contribution.
   c. When the employee is or could be covered by Medicare.

d. When the employee is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination.

e. When coverage for an Insured is terminated pursuant to items B. 5, 6 or 7 of the Cancellation Section.

4. Notice of Right to Continue Group Benefits: The Insured named on the Identification Card will be notified of their right to continue their group benefits. The Insured must provide written notification that they wish to continue their group coverage to the Company within 60 days of the date an event occurs which would qualify an Insured for continuation coverage under this provision. Upon receipt of the written notification from the Insured, the Company will send the employee or dependent who qualifies for continuation of group benefits a notice of the amount of premiums needed for the continuation benefits. A period of 45 days from the date the Insured elects to continue group benefits is allowed in which to pay the initial required premiums. The first premium payment will be for a period commencing with the date following the date coverage would otherwise terminate. No gap in coverage will be permitted.

   Subsequent premium payments will be allowed a 30-day grace period after the due date. The Company will bill the Insured directly and payment will be made directly to the Company.

D. Conversion Privilege

1. A conversion privilege is available to the following persons:

   a. Those who have completed the period of Continued Group Benefits provided for in Section A, B, or C above if Blue Cross and Blue Shield of Kansas is the insurer or administrator of that employer group health plan at the termination of such benefits.

   b. Those who during the period of Continued Group Benefits provided for in Section A, B, or C above choose to change to the Conversion Contract and so notify the Company. (So doing forever forfeits any right to further Continued Group Benefits.)

   c. Those who at the time of initial eligibility for Continued Group Benefits under Section A or B above choose to go directly at that time to the Conversion Contract. (So doing forever forfeits any right to Continued Group Benefits.)

   d. Those who do not qualify for Continued Group Benefits under either Section A or B above.

2. A conversion privilege is not applicable to Insureds who have their coverage terminated pursuant to items B.5, 6, or 7 of the Cancellation Section or to the following persons if the benefits referred to in paragraph b. below for such person or benefits provided or available under the sources referred to in paragraphs c. and d. below for such person, together with the benefits provided by the converted policy, would result in over-insurance based on Company standards as filed with the Kansas Insurance Department:

   a. Those who are or could be covered by Medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded).

   b. Those who are covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program, or

   c. Those who are eligible for similar benefits (whether or not covered therefore) under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, or

   d. Those who have or have available similar benefits pursuant to or in accordance with the requirements of any state or federal law.

3. Conversion Notice

   The Company will mail a conversion notice to those persons specified in Section D.1. Within 31 days of receipt of the notice, the person has the right to apply for coverage by remitting the required premiums. The first required premium payment will be for a period commencing with the day following the date coverage would otherwise terminate. No gap in coverage will be permitted.

   Persons who are enrolled in Continued Group Benefits will be mailed the conversion notice prior to the end of the period for continued group benefits.

   a. Notice to the Insured named on the Identification Card: The notice will be mailed to the Insured's latest address as it appears on the records of the Company.

   b. Notice to dependents who cease to be eligible: The notice will be mailed to the dependent at the address provided the Company when the Company is notified that such person is no longer an eligible dependent.

4. The contract does not require evidence of insurability of the person to be covered.

BLUE CHOICE RIDER

PART 1. GENERAL

This is a Rider to Your Certificate. It becomes effective on the date shown in the records of Blue Cross and Blue Shield of Kansas.

The conditions described in Your Certificate also control this Rider except where this Rider specifically states there is a change.

PART 2. ENROLLMENT IN BLUE CHOICE

The Contract Holder and Insured agree to the following related to the offering of Blue Choice and the Insured's enrollment therein:

A. Blue Choice Providers

"Blue Choice Provider" means an Institutional Provider or Professional Provider of health care services that has entered into an agreement with the Company under which it is classified as a Blue Choice Provider.

"Blue Plan Preferred Provider" means an Eligible Provider that has entered into an agreement with a Blue Cross and/or Blue Shield Company (other than Blue Cross and Blue Shield of Kansas) under which additional deductibles and/or coinsurances for use of a non-preferred provider do not apply to such Eligible Provider.

The Company will provide the Contract Holder with listings of the Blue Choice Providers in the Company Service Area. You may call the number listed on the Insured's Identification Card if You wish to determine if a provider outside the Company Service Area is a Blue Plan Preferred Provider.

B. Use Blue Choice Providers or Blue Plan Preferred Providers

To receive the maximum level of benefits from Your Blue Choice coverage, You must use Blue Choice or Blue Plan Preferred Providers. Section C describes the lesser benefits when non-Blue Choice Providers or non-Blue Plan Preferred Providers are used.

C. Additional Coinsurance

You will be responsible for an additional 20% of the Allowable Charge up to a maximum additional coinsurance of $2,000 per Insured per Benefit Period or $4,000 for all Insureds on family coverage per Benefit Period that would otherwise be allowable if You fail to use a Blue Choice Provider or a Blue Plan Preferred Provider. This additional coinsurance does not accumulate toward the satisfaction of any other deductible, coinsurance or shared payment called for by Your Certificate, and those other deductibles, coinsurances or shared payment amounts called for by Your Certificate continue to apply.

The additional coinsurance is not applied when service is required for a Medical Emergency or a life, limb, or function-threatening Accidental Injury.

The Company has no obligation to advise You of the applicability of additional coinsurances for use of a non-Blue Choice Provider or a non-Blue Plan Preferred Provider during the course of pre-authorization or otherwise. You are responsible for choosing their providers of health care services.

Form RI-438 1/14

SUPPLEMENTAL ENDORSEMENT ISSUED BY BLUE CROSS AND BLUE SHIELD OF KANSAS, INC.

As a Blue Cross and Blue Shield of Kansas Insured You have the opportunity to take advantage of savings programs that are collectively called Resource Blue which are being offered at no additional cost to You. These programs are not insurance but instead discount programs that will help You with specified expenses for services that are not eligible for coverage under Your Blue Cross Blue Shield of Kansas coverage.

The types of services included are:

- Vision Care
- Hearing Care
- Complementary and Alternative Medicine

Disclaimer

The above savings programs are made possible through arrangements with various providers and vendors. Changes in these arrangements and/or their discontinuance may occur in the future at the discretion of Blue Cross and Blue Shield of Kansas.

Form 80-2113 7/05

GROUP: 09327

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ISSUED TO: SAMPLE 10/06/2015
GROUP ID: 09327 INSURED ID: SAMPLE

Women's Health Care and Cancer Rights Act (WHCRA) Notice

In accordance with the requirements of WHCRA and K.S.A. 40-2, 166 Blue Cross and Blue Shield of Kansas is notifying you of the following coverage mandated by state and federal law. When the need for such benefits is determined by the Insured and the Insured's attending physician, benefits include the following:

- Reconstruction of the breast on which a mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatments for physical complications of all stages of mastectomy, including lymphedemas.

Normal deductible, coinsurance, and/or copay amounts applicable to your health coverage are also applicable to these benefits.

BlueCross BlueShield of Kansas

An Independent Licensee of the
Blue Cross Blue Shield Association.

GROUP NAME: USD 262 VALLEY CENTER

GROUP NUMBER: 09327

ISSUED TO: SAMPLE

IDENTIFICATION NUMBER: SAMPLE

Form FL-793 1/14

ISSUED TO: SAMPLE 10/06/2015
GROUP ID: 09327 INSURED ID: SAMPLE

10/05/2015

ISSUED TO: SAMPLE 10/06/2015
GROUP ID: 09327 INSURED ID: SAMPLE

An Independent Licensee of the
Blue Cross Blue Shield Association.

The following information is either provided to you as an insured, or is available to you upon request:

- A complete description of the health care services, items and other benefits to which you are entitled.
- A complete description of limitations, exceptions and exclusions of your health benefit plan.
  - A listing of contracting providers, their business addresses, telephone numbers, availability and any network limitations.
  - A notification in advance of any changes in the health benefit plan which either reduces coverage or benefits, or increases the cost of the plan.
  - A description of the appeal procedures available under the health benefit plan and your rights regarding termination, disenrollment, nonrenewal or cancellation of coverage.

GROUP NAME: USD 262 VALLEY CENTER

GROUP NUMBER: 09327

ISSUED TO: SAMPLE

IDENTIFICATION NUMBER: SAMPLE

Form FL-794 1/14

10/05/2015

ISSUED TO: SAMPLE 10/06/2015
GROUP ID: 09327 INSURED ID: SAMPLE

10/05/2015

ISSUED TO: SAMPLE 10/06/2015
GROUP ID: 09327 INSURED ID: SAMPLE

Privacy of financial information is of concern to all of us, and in response to these concerns, the federal government has required states to adopt laws that require insurance companies to explain their privacy practices. This federal law is commonly referred to as Gramm-Leach-Bliley and is separate from the federal law commonly referred to as HIPAA Privacy which became effective on 4/14/2003 and for which You have been sent the Notice of Privacy Practices concerning protected health information as required by that law. Our privacy practices for "non-public personal financial information" are set out below. We want to assure You that we take Your privacy concerns seriously, and join with Your lawmakers in believing this disclosure of such practices is an important idea.

OUR PRIVACY PRACTICES REGARDING FINANCIAL INFORMATION

Blue Cross and Blue Shield of Kansas has the following practices regarding nonpublic personally identifiable financial information with respect to our customers.

The nonpublic personal financial information we collect consists of information You provide in applications or enrollment forms (such as name, address, social security number, telephone number), or changes in that information You submit to us, and whether You hold other health coverage.

We collect such information from the following sources:

- Information we receive from You on applications or other forms;
- Information about Your transactions with us and our affiliate;
- Information we receive from others, if You hold duplicate coverage subject to coordination with coverages we issue or administer.

We do not disclose such information about our customers or former customers to anyone except:

- We disclose such information as permitted by law. Examples of disclosures we make which are permitted by law include disclosures of the fact of enrollment (a type of personally identifiable financial information) collected by one affiliate to the other, disclosures to persons providing services to us necessary to adjudicate claims, and disclosures to health care providers allowing such providers to determine your eligibility for coverage.
- We may disclose Your name, address and telephone number which we receive from You on Your applications or other forms to companies that perform customer satisfaction or other surveys on our behalf. Such companies have agreed not to redisclose such information to others.

We restrict access to nonpublic personal financial information about You to those employees who need to know that information to provide products or services to You. We maintain physical, electronic, and procedural safeguards to guard Your personal financial information.

Form FL-12 5/08

ISSUED TO: SAMPLE 10/06/2015
GROUP ID: 09327 INSURED ID: SAMPLE

10/05/2015

An Independent Licensee of the
Blue Cross Blue Shield Association.

COMPREHENSIVE MAJOR MEDICAL GROUP CERTIFICATE

This Certificate describes the benefits provided in a Group Contract by Blue Cross and Blue Shield of Kansas, Inc. (herein called "Blue Cross and Blue Shield of Kansas" or "the Company") Topeka, Kansas, and the exclusions and limitations. This Certificate may be canceled as described in this Certificate.

To the extent that benefits of this Certificate are part of an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act (commonly known as ERISA), Blue Cross and Blue Shield of Kansas shall have the full and exclusive authority to construe covered benefits that are stated in the Certificate.

GROUP NAME:	USD 262 VALLEY CENTER
GROUP NUMBER:	09327
ISSUED TO:	SAMPLE
IDENTIFICATION NUMBER:	SAMPLE

You have specific consumer rights regarding internal and external appeals. Our complete appeals procedure process is available in Spanish. To request a Spanish version of the appeals process, please call our Customer Service number on the back of your member identification card.

Usted tiene derechos específicos como consumidor con relación a las apelaciones internas y externas. Nuestro proceso completo para el procedimiento de apelaciones está disponible en español. Para solicitar una versión en español del proceso de apelaciones, llame a nuestro número de Servicio al cliente que se encuentra en la parte posterior de su tarjeta de identificación del afiliado.

Form FL-836 1/15

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GENERAL DEFINITIONS

A. **Accidental Injury** is an unintended injury to Your body caused through external means. "Accidental Injury" does not include: injuries that occur before the date from which You have had continuous coverage with the Company; disease or infection (except for infection that occurred from an accidental cut or wound); hernia; injuries to the teeth caused by biting or chewing.

B. **Alternate Recipient** means any child of an Insured who is recognized under a Qualified Medical Child Support Order as having a right to enrollment under this Contract.

C. **Blue Cross Company and/or Blue Shield Company** means the Company and any other corporation approved or licensed by the Blue Cross Blue Shield Association to use the registered service marks and names.

D. **Certificate** means a summary of the provisions of the Group Contract that affect Insureds. A Certificate is issued by the Company to the Contract Holder for delivery to each enrolling employee.

E. **Coinsurance** means the percentage of the allowable charge for a covered service at which payment is made after any applicable Deductible amount has been satisfied.

F. **Company** means Blue Cross and Blue Shield of Kansas.

G. **Company Service Area** means the State of Kansas except Johnson and Wyandotte Counties.

H. **Contract or Group Contract** means the Contract between the Company and the Contract Holder and includes: all of the forms issued to the Contract Holder by Blue Cross and Blue Shield of Kansas, including endorsements, amendments, and riders.

I. **Contracting Provider** means an Eligible Provider who has entered into a Contracting Provider Agreement with the Company.

J. **Convalescent Care, Custodial/Maintenance Care or Rest Cures** means treatment or services, regardless of by whom recommended or where provided, in which the service could be rendered safely and reasonably by self, family, or other caregivers who are not Eligible Providers. The purpose of the services are designed mainly to help the patient with daily living activities, to maintain their present physical and mental condition, or provide a structured or safe environment.

K. **Copayment or Copay** means the amount of the allowable charge for a covered service required to be paid by an Insured before benefits can be provided.

L. **Credible Evidence** means scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations or consensus among experts.

M. **Deductible** means the amount of the allowable charges for covered services required to be paid by an Insured before benefits can be provided. Amounts applied toward the Deductible are accumulated until a specified dollar maximum has been reached during a Benefit Period after which no additional Deductible amount is required for the remainder of that Benefit Period.

N. **Eligible Provider** means any of the following providers when services provided are within the scope of the licensure of the provider. NOTE: Providers recognized by Medicare as Independent Diagnostic Testing Facilities (IDTFs) are not considered Eligible Providers unless they meet the applicable criteria as set out in the definitions below.

1. **Ambulance Service** means any form of transportation specially designed, equipped, and intended to be used for the purpose of transporting ill or injured persons and is operated according to state and local laws which control the issuing of valid licenses or permits for the operation of an Ambulance Service.

2. **Ambulatory Surgical Center** means a facility that meets all of the following criteria: (1) is licensed by the proper licensing agency as an ambulatory surgical center; (2) is not a part of a Hospital; (3) provides hospital-type services for Outpatient surgery.

3. **Professional Provider** means any of the following health practitioners licensed or certified to provide health services in the state of Kansas:

   - Advanced Registered Nurse Practitioner (ARNP)/Advanced Practice Registered Nurse (APRN);
   - Any of the following when authorized to engage in private, independent practice under the laws of the state in which covered services are received:
     - Licensed Clinical Marriage and Family Therapist (LCMFT);
     - Licensed Clinical Professional Counselor (LCPC);
     - Licensed Clinical Psychotherapist (LCP);
     - Licensed Specialist Clinical Social Worker (LSCSW);
   - Audiologist;
   - Autism Specialist or Intensive Individual Service Provider as defined by the Kansas Department for Aging and Disability Services;

- Certified Diabetic Educator/Licensed Dietitian (for covered diabetic education services);
- Doctor of Chiropractic (DC);
- Doctor of Dental Surgery (DDS);
- Doctor of Medicine (MD);
- Doctor of Osteopathy (DO);
- Licensed Physical Therapist (LPT);
- Occupational Therapist;
- Doctor of Optometry (OD);
- Oral Surgeon;
- Physician Assistant (PA);
- Doctor of Podiatric Medicine (DPM);
- Psychologist licensed to practice under the laws of the state in which covered services are received; and
- Speech-Language Pathologist.
- Licensed Mental Health Technician (LMHT)
- Licensed Practical Nurse (LPN)
- Registered Nurse (RN)
- Respiratory Therapist (LRT)
- Athletic Trainer (AT)
- Naturopathic Doctor (LND)
- Licensed Radiological Technologist (LRTC)
- Master Level Psychologist (LMLP)
- Addiction Counselor (LAC)
- Licensed Master/Bachelor Social Worker (LMSW/LBSW)
- Dental Hygienist (LDH)
- Dietician (LD)

4. **Free-Standing Birthing Center** means a facility, operated by a licensed physician, that performs uncomplicated normal/routine (i.e., non-Cesarean) deliveries of newborns.
5. **Free-Standing Cardiac Catheterization Laboratory** means:

   - A facility approved by Medicare to perform diagnostic cardiac catheterization procedures
   - Performs only diagnostic cardiac catheterization procedures
   - Does so in a non-Hospital outpatient setting

6. **Free-Standing Dialysis Center** means a facility approved by Medicare to perform dialysis and related services.
7. **Free-Standing Imaging Center** means a facility operated by a licensed physician and approved by Medicare to perform specialized diagnostic and radiologic tests.
8. **Free-Standing Sleep Center/Laboratory** mean a facility that only performs sleep studies.
9. **Home Health Agency** means:

   - A public agency or private organization which is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's place of residence.
   - Has policies established by a group of professional personnel which governs the skilled nursing and therapeutic services which it provides
   - Maintains clinical records on all patients
   - Is licensed according to state and local laws
   - Is certified by Medicare

10. **Hospital** means any of the following types of institutions:

    - The acute care, psychiatric, rehabilitation and long-term acute care sections of a licensed general hospital
    - Other facilities licensed by their state of operation as a hospital that provide acute care services
    - Licensed privately operated psychiatric hospitals
    - Health care institutions operated by the State of Kansas or the United States government

    Hospital does **not** include any of the following, even if licensed as a hospital:

    - Ambulatory Surgical Centers
    - Clinics
    - Doctors' offices
    - Facilities that are primarily for the care of convalescents
    - Health resorts
    - Nursing homes
    - Private homes
    - Residential or transitional living centers
    - Residential treatment centers or similar facilities
    - Rest homes
    - Skilled nursing facilities

11. **Independent Laboratory** means a medical laboratory that is CLIA-certified Medicare to perform diagnostic and/or clinical tests and is independent of an Institutional Provider or a Professional Provider's office.
12. **Institutional Provider** means a Hospital, Medical Care Facility, or Ambulatory Surgical Center.
13. **Medical Care Facility** means a facility that is not a Hospital (see definition) but that is: an alcoholic treatment facility; a drug abuse treatment facility; or a community mental health center. To qualify as a Medical Care Facility, the facility must also be licensed by the State of Kansas to provide diagnosis and/or treatment of a Mental Illness or Substance Use Disorder.
14. **Other Eligible Providers** (as limited herein)
    a. Adjunct Providers means only the following providers that perform Covered Services under the direction of a Professional Provider.
        1. Certified Occupational Therapy Assistant
        2. Certified Physical (Therapy) Therapist Assistant
    b. Registered Nurse and Licensed Practical Nurses are Eligible Providers for Home Health Care and Private Duty Nursing only, but may also perform services incidental to and on behalf of services rendered and billed by a Professional Provider. Examples include, but are not limited to injections/immunizations, ECGs, and pulmonary function testing. Certified Registered Nurse Anesthetists (CRNA) are also Eligible Providers for anesthesia services.
    c. Orthopedic/Prosthetic Device Supplier
    d. Home Medical Equipment Supplier
    e. Infusion Therapy Providers licensed to provide infusion therapy in the state in which services are received, e.g., infusion suites, home infusion therapy providers.
    f. Specialty Pharmacy for dispensing Specialty Prescription Drugs eligible for coverage under the Comprehensive Program.
    g. Hospice means a Medicare Certified organization or agency providing comprehensive, continuous Outpatient and home-like Inpatient care for terminally ill patients and their families and is licensed to practice under the laws of the state in which covered services are received.

O. Eligible Provider for Mental Illness or Substance Use Disorders

- A Hospital;
- A Medical Care Facility;
- A Licensed Doctor of Medicine, or Doctor of Osteopathy;
- A psychologist licensed to practice under the laws of the state in which covered services are received;
- A Licensed Specialist Clinical Social Worker authorized to engage in private, independent practice under the laws of the state in which covered services are received;
- Advanced registered nurse practitioner;
- A Licensed Clinical Marriage and Family Therapist;
- A Licensed Clinical Professional Counselor;
- A Licensed Clinical Psychotherapist.

P. Except as limited is a phrase You will see before explanations of Covered Services. It means that all coverage under this Certificate is controlled by the conditions described in this Certificate, including exclusions.

Q. Experimental or Investigational refers to the status of a drug, device, medical treatment or procedure:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished and the drug or device is not Research-Urgent as defined in these General Definitions except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or
2. if Credible Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not Research-Urgent as defined in these General Definitions except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or
3. if Credible Evidence shows that the consensus among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not Research-Urgent as defined in these General Definitions except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment

of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or

4. if there is no Credible Evidence available that would support the use of the drug, device, medical treatment or procedure compared to the standard means of treatment or diagnosis except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

R. **Identification Card** means a card issued to identify You as an Insured of the Company.

S. **Inpatient** means a setting where services are provided when You have been admitted to a Hospital or Medical Care Facility.

T. **Insured** means the person named on the Identification Card.

Insured also means the following persons that have been duly enrolled in the Company's records according to the specifications set forth in the Enrollment and Effective Dates Section:

1. The husband or wife of the person named on the Identification Card; and
2. Each dependent child by birth, adoption, legal guardianship, or court-ordered custody of the Insured named on the Identification Card or such person's spouse, who is:
   a. Under 26, or
   b. Age 26 or over provided the child is unmarried and covered as a dependent child under a policy or certificate issued by the Company or other creditable coverage (as defined under HIPAA) upon reaching age 26, has no more than a 63-day gap in dependent or handicapped dependent coverage prior to application for coverage hereunder, and is incapable of self-support due to a severe handicap resulting from a physical condition or a Mental Illness or Substance Use Disorder prior to their 26th birthday. For such a child to be an Insured, You must request from and submit to the Company a special application within 63 days of the latter of the following: a) the child's 26th birthday (but no earlier than 60 days prior); or b) the first opportunity for the child to enroll for coverage hereunder or accrual of a special enrollment right pursuant to HIPAA. The Company will then determine the child's eligibility. If the child is eligible, the coverage will be effective according to the specifications set forth in the Enrollment and Effective Dates Section.

      The Company will request written proof from time to time related to this child's incapacity and dependence. This child's coverage will end when the child is no longer disabled or dependent.

Insured does not refer to persons who have been voluntarily disenrolled by the person named on the Identification Card.

U. **Intensive Care Unit** means a specialized room or area or section in a Hospital which includes:

- Beds in a distinctly identifiable unit that are used only for critically ill or injured patients
- A separate nursing staff, with a qualified Registered Nurse in 24-hour attendance while the unit is occupied ("Qualified" means the nurse has had special training in intensive care nursing.)
- Special supplies and equipment needed to care for critically ill or injured patients

V. **Medical Emergency** means a sudden and, at the time, unexpected onset of a health condition that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect to require immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. Medical Emergency does not include the onset of a health condition while an Inpatient.

W. **Medically Necessary** describes a service or supply performed, referred or prescribed by a provider in the most appropriate setting and consistent with the diagnosis and treatment of the patient's condition in accordance with generally accepted standards of medical practice in the United States based on credible scientific evidence and not primarily for the convenience of the patient, physician, or other health care provider.

X. **Medicare** means Title XVIII of the Social Security Act as amended now and in the future, any rules and regulations authorized by any agency authorized to administer that Act.

Y. **Mental Illness or Substance Use Disorder** means a disorder specified in the Diagnostic and Statistical Manual of the American Psychiatric Association IV (1994). This does not include any condition or problem that is designated in the DSM IV (1994) as a focus of clinical attention.

Z. **Non-Contracting Provider** means an Eligible Provider who has not entered into a Contracting Provider Agreement with Blue Cross and Blue Shield of Kansas.

AA. **Open Enrollment** means the period of time during which eligible persons who have not previously enrolled with the Company within the time periods specified, following their first opportunity or an event, as defined by state or federal law, that qualifies them for coverage, may do so. This time period is the 30 days preceding

the anniversary month of the Contract Holder. If agreed upon by the Contract Holder and the Company, different, additional or longer Open Enrollment Periods may be established.

BB. Outpatient means a setting where provided services are other than as an Inpatient in a Hospital or Medical Care Facility. These settings include but are not limited to the Outpatient department of a Hospital, an Ambulatory Surgical Center, a clinic or a Professional Provider's office.

CC. Rehabilitation Services means therapies that, when provided in an Inpatient or Outpatient setting, are designed to restore physical functions following an Accidental Injury or an illness.

DD. Research-Urgent means a drug, device, medical treatment or procedure that is otherwise excluded by this Certificate as Experimental or Investigational (see General Definitions and General Exclusions) but meet all the following criteria:

1. It is therapeutic (not diagnostic or supportive) treatment used to directly improve health outcomes for a condition that is either life threatening or severely and chronically disabling and that has a poor prognosis with the most effective conventional treatment.
   a. For purposes of Research-Urgent Benefits a condition is considered life threatening if it has a substantial probability of causing premature death and all other conventional treatments have failed.
   b. For purposes of Research-Urgent Benefits a condition is considered severely and chronically disabling if the individual with the condition is unable to perform even the functions that are required for daily life and if the severe disability is not expected to improve with the most effective conventional treatment.
2. There is Credible Evidence that the treatment may provide a clinically significant and substantial improvement in net health outcome compared to the most effective conventional treatment, or where conventional treatment has failed or is not medically appropriate.
3. Regardless of funding source, the drug, device, medical treatment or procedure is available to the Insured seeking it and will be provided within a well designed clinical trial conducted by the National Institute of Health, Inc. or by an institution or entity which the protocol for the drug, device, medical treatment or procedure has been approved by an Institutional Review Board that is in compliance with the ethical principles in: (a) The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research or the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, or (b) other appropriate ethical standards recognized by federal departments and agencies that have adopted the Federal Policy for the Protection of Human Subjects.

EE. Sound Natural Tooth means a tooth that is whole or properly restored; is without advanced periodontal disease and is not in need of the treatment provided for any reason other than an Accidental Injury.

FF. Utilization Review means an evaluation of the medical necessity, appropriateness, and efficiency of use of health care services, procedures, and facilities.

The claims review is done by consulting practicing Doctors in cooperation with Your Doctor.

GG. You and Your refer to the Insured.

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ENROLLMENT AND EFFECTIVE DATES

A. Initial Establishment of Coverage

The Contract Holder (or employer if different) shall submit to the Company an individual application for each eligible employee electing coverage. These applications will be accepted if received by the Company within 60 days of the person's date of initial eligibility to enroll.

If the Contract Holder offers a choice of two or more optional health benefit programs, an Insured may elect only one of the programs offered.

For those who are enrolling at their initial opportunity, coverage will be effective on the first of the month following the initial opportunity to enroll as long as the application is received by the Company within 60 days of the person's initial opportunity to enroll.

For those who do not make application within the time periods set forth above, but who are enrolling in conjunction with an event, as defined by state or federal law, that qualifies them for coverage, such coverage will be effective on the first of the month following the event that qualifies them for coverage as long as the application is received by the Company within 60 days of the event except when the event is birth, adoption, placement for adoption, or discharge from the military in which case the effective date will be the date of the event.

B. Adding Dependents

The Contract Holder (or employer) shall notify the Company in writing when an Insured's coverage should be changed to either add or drop a dependent or dependents when such a change would result in the establishment of a different coverage type, e.g., employee only coverage to employee/spouse coverage or vice versa. If the notice of change is received by the Company within 60 days of the Insured's marriage date or the date of the event, as defined by state or federal law, which qualifies the dependent for coverage hereunder, such change will be accepted. Changes in coverage type will be the first of the month following the date the dependent became eligible for coverage.

C. Care for Newborns and Mothers

Inpatient services in a Hospital are covered for at least 48 hours following a vaginal delivery and at least 96 hours following delivery by a cesarean section for the newborn child of an Insured and the mother (if an Insured) of such newborn.

The Company has the right to determine the medical necessity of any length of stay beyond the 48-96 hours described above.

In the event that coverage hereunder provides benefits for only the parent(s) of the newborn child, coverage must be changed to a type that provides benefits for dependent children within the time period required for such change (as set forth above) in order for the newborn child's coverage to continue beyond the initial 48 or 96 hour periods described above.

Covered services received by the child prior to coverage being changed to a type that provides benefits for dependent children, will be treated as though they were services received by the parent Insured.

D. Newborn Child/Adopted Child Coverage

Notwithstanding any provision to the contrary, under existing coverage that provides benefits for two or more Insureds, a newborn of the person named on the Identification Card or the spouse of the person named on the Identification Card or a child (regardless of age) adopted by the Insured or placed in the Insured's home by a child placement agency as defined by state law for the purpose of adoption, is covered as follows:

1. In the case of natural newborns, newborns for which the petition for adoption has been filed within 31 days following birth, or newborns placed in the Insured's home within 31 days following birth, coverage will be effective and provided without charge for 31 days beginning on the date of birth.
2. In the case of adoptions subsequent to the first 31 days of birth, coverage will be effective and provided without charge for 31 days beginning on the date the petition for adoption was filed.
3. In the case of placement of a child in the Insured's home by a child placement agency as defined by state law for the purpose of adoption subsequent to the first 31 days of birth, coverage will be effective and provided without charge for 31 days beginning on the date of placement.

Under a coverage type that provides benefits for children, no change in coverage type is required. However, additional premiums may be required.

Under coverage that provides benefits for an employee or employee and spouse only, the coverage must be changed to a coverage type that would include the child in order for the child to have coverage beyond the first 31 days.

E. Dependent coverage pursuant to a Qualified Medical Child Support Order

Coverage will be effective on the first day of the month following the date on which the Company qualifies the order. Medical Child Support Orders must be qualified by the Contract Holder and the Company pursuant to specifications of federal and state law. The procedure for qualification is to timely submit the Medical Child Support Order to the Contract Holder for initial qualification or rejection. The Contract Holder will forward the order to the Company for qualification or rejection with notice to the parties to the order. If the order is qualified, an Identification Card, Certificate and claim form will be issued to the Alternate Recipient.

F. Coverage begins on the date this coverage becomes effective for the Insured as reflected in the records of Blue Cross and Blue Shield of Kansas and determined according to the provisions set forth in this Enrollment and Effective Dates section.

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G. Special Enrollment Rights

Special Enrollment Rights are recognized when an eligible employee, spouse, or dependent involuntarily loses group health plan or health insurance coverage in connection with designated qualifying events as outlined below or becomes eligible for state premium assistance as provided below, or when an eligible employee acquires a spouse and/or dependent(s). Under these circumstances, coverage may be added for certain individuals wishing to become covered hereunder if such individuals are otherwise eligible for coverage and enroll within 60 calendar days of the event creating the Special Enrollment Right.

The effective date of coverage arising from Special Enrollment Rights will be as provided in the applicable provision above in this Enrollment and Effective Dates section.

Special Enrollment Rights are recognized for the following qualifying events only:

1. Involuntary loss of other medical coverage in which:
   - -- The other coverage was the basis for You, Your spouse, and/or dependent(s) declining coverage hereunder; AND
   - -- The loss of other coverage occurred solely due to one of the following designated qualifying events: loss of eligibility for such coverage or exhaustion of COBRA or state continuation coverage. Note: Special Enrollment Rights are not recognized if coverage and/or eligibility was lost due to any of the following: failure on the part of the employee, spouse, or dependent, as applicable, to pay contributions/premiums on a timely basis, submission of fraudulent claims, or intentional misrepresentation of material information.
2. Complete cessation of employer contributions toward non-continuation group coverage
3. Marriage of employee
4. Birth
5. Adoption or placement for adoption
6. Becoming eligible for a state premium assistance program under Medicaid or a state Children's Health Insurance Program (CHIP).

Who accrues Special Enrollment Rights

The accrual of Special Enrollment Rights varies according to the qualifying events listed above. Special Enrollment Rights are recognized only for individuals as provided below:

1. For loss of other coverage or cessation of employer contributions: the employee, spouse, and any dependents losing such other coverage or employer contribution.
2. For marriage, birth, adoption, or placement for adoption: the employee, spouse, and any newly-acquired dependent(s) only.
3. For state premium assistance eligibility: the employee and any dependents.

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COMPREHENSIVE PROGRAM

A. Benefits

1. **Benefit Period:** The 12 month period beginning on April 1.
2. **Deductible per Benefit Period:** $1,000 for any one Insured, not to exceed $2,000 for all Insureds on family coverage (in aggregate). Charges incurred in the last three months of a Benefit Period that applied to the Deductible of that Benefit Period can also be applied to the Deductible of the next Benefit Period.
3. **Coinsurance:** After the Deductible has been met, the Company will make benefit payments for 80% of the allowable charge. When the amount You have paid in Coinsurance in the Benefit Period reaches $1,000 for any one Insured or $2,000 for all Insureds on family coverage (in aggregate), the amount payable for the rest of the Benefit Period will be 100% of the allowable charge.
4. **Annual Out-of-Pocket Maximum:** $6,350 for any one Insured not to exceed $12,700 for all Insureds on family coverage. No one Insured on family coverage will be required to contribute more than the single Annual Out-of-Pocket Maximum towards the family Annual Out-of-Pocket Maximum. Out-of-Pocket expenses include the Deductible, Coinsurance and Copayment provisions under the Comprehensive Program, Prescription Drug Program and Mail Order Prescription Drug Program. After You have reached the Annual Out-of-Pocket maximum, eligible services will be paid at 100% of the allowable charge for the remainder of the Benefit Period. If You are enrolled in a dental care program, Coinsurance applicable to the dental care program does not apply to this Annual Out-of-Pocket Maximum.
5. **Home or Office Visit Copay:** A Copay of $25 will apply to each home or office visit. Any amounts You pay to satisfy this Copay do not apply toward satisfaction of any other Deductible, Coinsurance, or Copayment/Copay, except amounts in excess of the allowable charge for a Home or Office Visit shall be used toward the satisfaction of Deductible, Coinsurance, or Copayments for other covered services rendered during the same Home or Office Visit. Such amounts shall not be credited towards applicable aggregate amounts for the Benefit Period.
6. **Immunizations and Injections:** Benefits for covered immunizations and injections provided on an Outpatient basis will be paid at 100% of the allowable charge.
7. **Outpatient Laboratory and Radiology Services**

   Services that are not associated with an Accidental Injury:

   Benefits for covered laboratory and radiology services provided on an Outpatient basis will be paid at 100% of the allowable charge up to a maximum payment of $300 per Insured per Benefit Period after which benefits are subject to the Deductible, Coinsurance and/or Copayment/Copay amounts required for other covered services.

   Services that are associated with an Accidental Injury:

   Benefits for covered laboratory and radiology services provided on an Outpatient basis will be paid at 100% of the allowable charge until the Enhanced Accidental Injury Benefit (see #9 below) has been exhausted. After the Enhanced Accidental Injury Benefit has been exhausted, all remaining allowable charges for covered laboratory and radiology services are subject to the Deductible, Coinsurance and/or Copayment/Copay amounts required for other covered services.
8. **Emergency Room Copayment:** A Copayment of $100 will apply to each Hospital emergency room visit (Applies only to Institutional Provider services, not to services of Professional Providers.) This Emergency Room Copayment is in addition to any other Deductible, Coinsurance or Copayment/Copay amounts. For services associated with an Accidental Injury, this Copayment shall not apply until the Enhanced Accidental Injury Benefit (see #9 below) has been exhausted. This Emergency Room Copayment is waived if the patient is admitted as an Inpatient within 24 hours to the same Hospital for treatment of the same condition.
9. **Enhanced Accidental Injury Benefit:** Payment will be made at 100% of the allowable charge for covered services associated with any and all Accidental Injuries incurred up to a maximum of $1,000 per Insured per Benefit Period.
10. **Preventive Health Benefits:** Each Insured is eligible to receive the following preventive services paid at 100% of the allowable charge when received from a Contracting Provider for preventive (i.e., not diagnostic or treatment) purposes. Preventive Health Services received from a Non-Contracting Provider will be subject to the cost-sharing requirements (including copayments, coinsurance and deductible), applicable hereunder, in a manner consistent with Section 2713 of Federal H.R. 3590 for:

    a. evidence-based items or services that have in effect, a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;

    b. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

c. with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

d. with respect to women, such additional preventive care and screenings not described in item (a) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph (including breast cancer screening and mammography screenings).

A list of the preventive services covered under this section is available on our website at www.bcbsks.com, or will be mailed to You upon request. You may request the list by calling the Customer Service number on Your Identification Card.

Note: Benefits for any prescription drug under this Preventive Health Benefits section will be provided only to the extent they are not available under other drug coverage You have through the Contract Holder.

11. **Any reduction made in allowable charges** due to the provider being non-contracting cannot be used to meet any Deductible, Coinsurance, Copayments and/or the Annual Out-of-Pocket Maximum if applicable.

12. **Mental Illness or Substance Use Disorders (Covered Services must be provided by an Eligible Provider for Mental Illness or Substance Use Disorders)**

    Benefits for Inpatient and Outpatient Mental Illness or Substance Use Disorder services that are Medically Necessary will be provided at the same payment level that is applicable to the service if it had been provided for a condition other than Mental Illness or Substance Use Disorder.

13. **Diabetic Education**

    Benefits for a covered diabetic education service will be subject to the same payment provisions as an office visit.

14. **Other Covered Services:** Unless otherwise specified, all covered services shall be subject to the applicable Deductible, Coinsurance, Copayments and/or other payment provisions described herein.

15. **Insured Responsibility:** Unless otherwise specified, all covered services shall be subject to the applicable Deductible, Coinsurance, Copayments and/or other payment provisions described herein.

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B. General

1. All coverage under this section is subject to the service having been ordered by a Professional Provider with the legal authority to order such service, furnished or performed and billed for by an Eligible Provider with the legal authority to provide such service, and is Medically Necessary.

2. You have the right to select Your own provider. However, the Company does not guarantee the availability of any service and benefits shall be provided according to the cost-containment policies and procedures applicable to Contracting Providers, regardless whether Your Provider is actually a Contracting Provider.

3. "Except as limited" is a phrase You will see before explanations of services. It is a reminder that the terms of this Certificate -- especially exclusions -- may restrict Your benefits.

4. Prior Authorization is required for some Prescription Drugs covered under this Comprehensive Program. A list of those drugs is available on www.bcbsks.com or by contacting customer service. To obtain prior authorization Your physician must provide appropriate records to the Company prior to providing services and the Company will authorize coverage if the medical necessity is supported. Failure to obtain prior authorization will not result in a denial of benefits if medical necessity is supported when the claim is adjudicated.

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C. Covered Services

1. **Hospital and Medical Care Facility services for Inpatients --** Except as limited, the following are covered:

   a. Room accommodation, dietary and general nursing service, nursery care.

      Limitation: If You occupy a private room, only the average semi-private room rate (based on the provider's rates for rooms with two or more beds) is covered.

   b. Intensive Care Unit facilities and services.

      Limitation: If You occupy an Intensive Care Unit room when it is not Medically Necessary but it is Medically Necessary for You to be in the Hospital, only the Hospital's average semi-private room rate (based on rates for rooms with two or more beds) is covered on such days.

   c. Operating room services.

d. Delivery room service. (Including the obstetrical and delivery expenses of the birth mother of a child adopted within 90 days of birth of such child).

e. Surgical preparatory and recovery room services.

f. Clinical laboratory and pathology services.

g. Diagnostic radiology services and Imaging studies.

h. Radiation therapy

i. Drugs approved for use in the United States by the U.S. Food and Drug Administration, except drugs approved for experimental use and drugs for take-home use.

j. Surgical dressings, splints, and casts.

k. Chemotherapy, other than High-Dose Chemotherapy, for malignant conditions. (See the Special Situations section for High-Dose Chemotherapy with Hematopoietic Support benefits.)

l. Prostheses that require surgical insertion into the body and are furnished and billed by the Hospital or Ambulatory Surgical Center. This does not include artificial eyes, ears, and limbs.

m. Setups for intravenous solutions.

n. Setups for blood transfusions, (including Blood plasma).

o. Oxygen and use of equipment for its administration.

p. Radioactive isotopes.

q. Electroencephalograms (EEGs) and electrocardiograms (EKGs).

r. Inhalation therapy/breathing treatment.

s. Physical or occupational therapy.

t. Anesthesia, including general anesthesia and facility charges for dental care provided to the following covered persons: (a) A child five (5) years of age and under; (b) A person who is severely disabled; (c) A person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided.

u. Hemodialysis.

v. Services for a Mental Illness or Substance Use Disorder.

Prior Authorization Requirement

Inpatient admissions to Hospitals and Medical Care Facilities require prior authorization by the Company unless the admission is for a Medical Emergency, a life-threatening condition, for obstetrical care or occurs outside the 50 United States.

You or Your Doctor will need to notify the Company to obtain the prior authorization. Notice should be given to the Company at least 72 hours in advance of the planned admission and should include: The patient's name, date of birth, identification number, telephone number, address, Hospital name, planned date of admission, reason for admission, admitting physician's name. The notification may be telephoned to the Company at the telephone number on the Insured's Identification Card.

The Company has the right to request and obtain whatever medical information it considers necessary to determine whether admission as an Inpatient is Medically Necessary. If it is, the Company will notify You, the Hospital and the admitting physician of approval. If inpatient admission is not deemed Medically Necessary You will be notified, as will be the Hospital and admitting physician. Prior authorization of an admission or any service is related solely to the medical necessity of the service and is not a determination of the eligibility of the service under other provisions of this Certificate.

If You fail to obtain a necessary prior authorization, the Company will review that admission for medical necessity. No coverage will be provided under this Program for services determined to be medically unnecessary. Only that portion of the inpatient claim that would normally be payable if services were received as an outpatient will be covered.

2. **Hospital Services for an Outpatient.**

   Except as limited, Covered Services by a Hospital for an Outpatient will include all services listed in C.1.c through v when the service is received in the Outpatient department of the Hospital.

3. **Ambulatory Surgical Center Services.**

   Except as limited, the services listed in C.1.c through u are covered when billed by an Ambulatory Surgical Center.

4. **Professional Provider Services.**

Except as limited, the following are covered:

Surgery and anesthesia services to include coverage for the administration of general anesthesia for dental care provided to the following covered persons: (a) A child five (5) years of age and under; (b) A person who is severely disabled; (c) A person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided.

Treatment of fractures and dislocations.

Biopsies and aspirations.

Endoscopic (scope) procedures.

Maternity services (including the obstetrical and delivery expenses of the birth mother of a child adopted within 90 days of birth of such child).

Medical (non-surgical) services for Inpatients in a Hospital or Medical Care Facility. (See 4.a for details of this benefit.)

Diagnostic radiology services and Imaging studies.

Diagnostic laboratory services.

Radiation therapy.

Chemotherapy, other than High-Dose Chemotherapy, for malignant conditions. (See 4.b for details of the standard chemotherapy benefit and the Special Situations section for High-Dose Chemotherapy with Hematopoietic Support benefits.)

Diagnostic radio isotope studies.

Electroencephalograms (EEGs) and electrocardiograms (EKGs).

Rehabilitation services. (See 4.d for details of this benefit.)

Home and office visits.

Immunizations, injections and infusions subject to any prior authorization requirements of this Certificate that are otherwise applicable to these services.

Allergy testing.

Transfusions (but not the cost of the blood itself).

Oral surgery and certain other dental services. (See 4.c for details of this benefit.)

Pap Smears.

Prescription contraceptive devices including placement and fitting of the device itself.

Surgical procedures for the implantation of Bone Anchored Hearing Aids (BAHA).

Services for a Mental Illness or Substance Use Disorder.

Coverage for Prostate Cancer Screening for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older. The screening may consist of a Prostate Specific Antigen (PSA) test and/or a digital rectal examination.

Coverage for services related to diagnosis, treatment and management of osteoporosis for individuals with a condition or medical history for which bone mass measurement is medically necessary for such an individual. Coverage is subject to the same Deductible, Coinsurance and other limitations as apply to other covered services.

Diagnosis and treatment of cause of infertility

a. The covered Medical (Non-Surgical) Services for Hospital or Medical Care Facility Inpatients include:

(1) Visits by the attending Doctor.

Limitations:

(a) During a stay for surgery, Medical (Non-Surgical) Services given by a Doctor other than the surgeon will not be covered unless they are Medically Necessary.

(b) If non-surgical treatment is given by two (2) or more Doctors at the same time, only one (1) Doctor will be paid for services.

(2) Consultations.

The first visit of a Doctor to give professional advice about Your condition is covered if the visit is requested by the attending Doctor and Your condition requires special skill or knowledge. This

consultation benefit is normally limited to one (1) during each Hospital stay. However, additional consultations may be approved with individual consideration of Your condition.

Consultations required by Hospital rules and regulations are not covered.

(3) Well Baby Care.

This covered service is for care of a well newborn during the mother's stay. It includes the normal Inpatient medical care for a newborn. The child must meet the applicable Deductible then this service is payable at the applicable Coinsurance amount.

b. Chemotherapy for malignant conditions.

(1) Chemotherapy administration services.

(2) Chemotherapy drugs that are injected or given intravenously or taken by mouth and under the direct supervision of Your Doctor. Prescription Drugs for chemotherapy are covered under the health benefits section of this coverage only if You are not enrolled in prescription drug coverage.

(3) Home and office visits for treatment of an adverse reaction to chemotherapy.

(4) Any other services related to chemotherapy that are specifically stated as covered.

c. Oral Surgical Services and Services for Accidental Injuries to Sound Natural Teeth, limited to:

(1) Surgical procedures of the jaw and gums.

(2) Removal of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

(3) Removal of exostoses (bony growths) of the jaw and hard palate.

(4) Treatment of fractures and dislocations of the jaw and facial bones.

(5) Surgical removal of impacted teeth.

(6) Treatment (including replacement) for damage to or loss of Sound Natural Teeth caused by an Accidental Injury.

(7) Intra oral dental imaging services in connection with covered oral surgery if such oral surgery occurs within 30 days of the imaging service(s.)

(8) General anesthesia.

(9) Cylindrical endosseous dental implants, mandibular staple implants, subperiosteal implants and the associated fixed and/or removable prosthetic appliance when provided because of an Accidental Injury.

(10) Cylindrical endosseous dental implants, mandibular staple implants, subperiosteal implants and the associated fixed and/or removable prosthetic appliances following surgical resection of either benign or malignant lesions (NOT including inflammatory lesions).

Exclusions: The extraction of teeth (except impacted teeth); fillings; prophylaxis (cleaning); scaling, scraping and/or root planing; dentures; straightening of teeth; and other dental services not listed as covered.

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d. Covered Rehabilitation Services. Except as limited, the following Rehabilitation Services are covered on both an Inpatient and Outpatient basis:

(1) Physical medicine modalities, including but not limited to: correction or adjustment by manual, mechanical, electrical or physical means (including the use of light, heat, water or exercise) of structural imbalance, distortion, subluxation or displaced tissue of any kind or nature of the human body.

(2) Physical therapy.

(3) Occupational therapy. (The materials used are excluded.)

(4) Speech therapy, limited to one service per day up to a maximum benefit of 90 daily services per Insured per Benefit Period. This limitation is not applicable to Mental Illness or Substance Use Disorders.

(5) Respiratory therapy.

(6) Neuropsychological testing.

(7) Cardiac Rehabilitation program or provider approved by the Company.

(8) Pulmonary rehabilitation program or provider approved by the Company.

Limitations:

(1) Services are covered only if they are expected to result in significant improvement in the Insured's condition. The Company, with appropriate medical consultation, will determine whether significant improvement has occurred.

(2) Cardiac and pulmonary rehabilitation programs are covered services only when provided by a provider whose program has been approved by the Company. You can obtain a list of approved programs, by calling the Customer Service number on Your Identification Card.

Exclusions:

(1) Vocational rehabilitation. Vocational rehabilitation is a process to restore or develop the working ability of the physically, emotionally or mentally disabled patients to the extent that they may become gainfully employed. This may include services provided to determine eligibility or provide treatment for vocational rehabilitation, to include but not limited to counseling, work trials and driving lessons.

(2) Therapies designed to evaluate and assist an individual in developing a program to complete their work and prevent physical damage or reinjury.

(3) Cognitive therapy. Cognitive therapy is a service provided to retain or enhance information processing due to brain damage or brain dysfunction which alters the way in which a person perceives or responds. These therapies include, but are not limited to treatment of memory loss, problem solving difficulties, short attention span, or inability to scan visually. Cognitive therapy services may also be known as multi-sensory programs, applied behavioral analysis, educational therapies, perceptual therapies, sensory integration, auditory integrative training, augmentative/alternative communication, discrete training trials, developmental therapy, or similar therapies. For the purposes of this Certificate, cognitive therapy services do not include neuropsychological testing.

e. Services for Autism Spectrum Disorder

(1) Definitions:

- Applied Behavior Analysis (ABA) means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior;
- Autism Spectrum Disorder (ASD) means a neurobiological disorder which includes autistic disorder, Asperger's disorder, pervasive developmental disorder not otherwise specified, Rett's disorder, and childhood disintegrative disorder when diagnosed by a licensed physician, licensed psychologist, or licensed specialist clinical social worker.

(2) Covered Services:

- ASD services include:
  - diagnostic evaluations performed by a licensed physician, licensed psychologist or licensed specialist clinical social worker;
  - treatment, including ABA therapy, limited to care, services, and related equipment prescribed or ordered by a licensed physician, licensed psychologist or licensed specialist clinical social worker;
- ABA therapy is limited to 1,300 hours per benefit period for four years beginning on the later of the date of diagnosis or January 1, 2015, for any covered individual diagnosed with Autism Spectrum Disorder between birth and five years (prior to the attainment of 60 months) of age; and
- 520 hours of ABA therapy per benefit period for any covered individual less than 12 years of age.
- Only those services actually provided on an hourly basis or fractional portion thereof by certified ABA providers are covered.
- ABA therapy services require prior authorization by the Company. You or Your doctor will need to notify the Company to obtain prior authorization. Notice should be given to the Company at least 72 hours in advance of the planned ABA therapy services and should include: the patient's name, date of birth, identification number, telephone number, address, the name of the prescribing physician, psychologist or licensed clinical specialist social worker and the date the patient was first diagnosed with autism spectrum disorder.

  The Company has the right to request and obtain whatever medical information it considers necessary to determine whether the ABA therapy services are Medically Necessary. If it is, the

Company will notify You and the treating provider of approval. If ABA treatment is not deemed Medically Necessary You and the treating provider will be notified.

If You fail to obtain a necessary prior authorization, the Company will review the ABA services for medical necessity. No coverage will be provided under this Program for services determined to be medically unnecessary.

(3) Exclusions:

- Full or partial day care or habilitation services, community support services, services at intermediate care facilities, school-based rehabilitative services, or overnight, boarding and extended stay services at facilities for autism patients; or
- Services that are otherwise provided, authorized or required to be provided by public or private schools receiving any state or federal funding for such services.

5. **Other Covered Services.**

Except as limited, the services listed below are covered:

a. Orthopedic, orthotic and prosthetic devices and appliances, including orthopedic braces, artificial limbs, artificial eyes, auditory osseointegrated devices.

Limitations:

(1) Benefits are not provided for eyeglasses and contact lenses.

Exception

- Benefits are available for the initial eyeglasses/contacts following surgery for cataracts, aphakia, or pseudophakia.
- An Insured under 12 years of age is eligible for subsequent eyeglasses/contacts following cataract surgery when there is a minimum change of .25 diopter.

(2) Benefits are not provided for hearing aids, hair prosthesis or dental appliances including plates, bridges, prostheses or braces.

(3) Benefits are not provided for items of wearing apparel except coverage is available for two post-mastectomy bras per Insured per Benefit Period. A post-mastectomy bra is a bra that is specifically designed and intended to support single or bilateral breast prostheses.

(4) Benefits are limited to the allowable amount for a basic/standard appliance which provides the essential function(s) required for the treatment or amelioration of the medical condition.

(5) Charges for deluxe or electrically operated appliances or devices are not covered beyond the allowable amount for basic/standard appliances. Deluxe describes medical devices or appliances that have enhancements that allow for additional convenience or use beyond that provided by a basic/standard device or appliance.

(6) Benefits are not provided for custom or over-the-counter orthotic devices, appliances including shoe inserts.

b. Medical Equipment and Supplies. Equipment for use in Your home is covered if:

- Prescribed by a Doctor for use in the home
- Not provided by a Hospital
- Serves a medical purpose
- Not an item that would ordinarily be of use to a person in the absence of a medical need. This includes items such as hemodialysis equipment, wheelchairs and hospital-type beds.

Medical Supplies: Coverage is also available for certain supplies as designated by the Company. You can obtain a list of covered supplies by contacting Customer Service at the number listed on Your Identification Card.

Limitations:

(1) Items for comfort or convenience are not covered. Included within the definition of convenience items are:

(a) Pieces of equipment used to provide exercise to functioning and non-functioning portions of the body when leased, purchased, or rented for use outside a recognized institutional facility.

(b) Those pieces of equipment designed to provide the walking capability for individuals with non-functioning legs

(2) The Company has the right to decide whether to provide for the rental or purchase of a covered item, to apply rental payments to purchase, and to stop covering rental when the item is no longer Medically Necessary.

(3) Benefits are limited to the allowable amount for a basic/standard item which provides the essential function(s) required for the treatment or amelioration of the medical condition.

(4) Charges for deluxe or electrically operated medical equipment are not covered beyond the allowable amount for basic/standard items. Deluxe describes medical equipment that has enhancements that allow for additional convenience or use beyond that provided by basic/standard equipment. For example, if an electric wheelchair is obtained, the benefit will not exceed the amount for a hand-operated wheelchair.

c. Allergy Antigens

d. Services associated with intravenous drug treatment including prescription drugs, supplies, and equipment and nursing services by Infusion Therapy Providers.

e. Diabetic Management.

(1) Equipment used exclusively with diabetes management.

Limitations:

Benefits are limited to the allowable amount for a basic/standard item; charges for deluxe items are not covered.

(2) Supplies: Coverage for diabetic supplies is provided under the Comprehensive Program only if the Insured does not have prescription drug coverage for such supplies. For purposes of this provision, diabetic supplies means syringes, needles, lancets, test strips and solutions, calibration strips, solutions and insulin pump supplies used exclusively with diabetic management.

(3) Outpatient self-management training and education, including medical nutrition therapy, for insulin dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes when provided by a certified, registered or licensed health care professional with expertise in diabetes and the diabetic (1) is treated at a program approved by the American Diabetes Association or American Association of Diabetes Educators; (2) is treated by a person certified by the national certification board of diabetes educators; or (3) is, as to nutritional education, treated by a licensed dietitian pursuant to a treatment plan authorized by such healthcare professional.

f. Genetic Molecular Testing only in the following situations:

(1) When there are signs and/or symptoms of an inherited disease in the affected individual, there has been a physical examination, pre-test counseling, and other diagnostic studies, and the determination of the diagnosis in the absence of such testing remains uncertain and would impact the care and management of the individual on whom the testing is performed.

(2) BRCA 1 and/or BRCA 2 testing when there are signs and/or symptoms of an inherited disease as specified above, or when signs and/or symptoms are not present but the testing has been prior authorized according to the criteria established by the Company.

As used herein, "Genetic Molecular Testing", means analysis of nucleic acids used to diagnose a genetic disease, including but not limited to sequencing, methylation studies and linkage analysis.

6. **Emergency Services.** Services necessary to provide an Insured with evaluation and stabilizing treatment when provided for a Medical Emergency.

7. **Ambulance Service.**

Except as limited, Ambulance Services that are Medically Necessary are covered:

- To the place of treatment following an Accidental Injury or Medical Emergency
- To a Hospital for care as an Inpatient
- From a Hospital where You have been an Inpatient
- For transfer of an Inpatient to another Hospital for care as an Inpatient.
- A 500-mile radius of the place where You are picked up, by the least expensive means or transport that meets the medical need.

D. Special Situations

1. **Case Management**

Case Management is a process conducted by the Company which:

a. identifies cases involving an Insured which presents either the potential for catastrophic claims or a utilization pattern that exceeds the norms and demonstrates or has the potential for atypical utilization of services;

b. assesses such cases for the appropriateness of the level of patient care and the setting in which it is received;

c. reviews services requested by the provider for potential alternative use of benefits or coordination of existing benefits; and

d. evaluates and monitors the requested services for cost efficient use of benefits.

The services may include both covered services and non-covered services with the exception of specifically stated exclusions. Total benefits paid for such services shall not exceed the total benefits to which the Insured would otherwise be entitled under the terms of this Certificate.

If the Company elects to provide benefits for an Insured in one case, it shall not obligate the Company to provide the same or similar benefits for the same or another Insured in the same or another case.

Participation in Case Management is voluntary. The Insured may withdraw at any time and return to the stated benefits of this Certificate.

2. **Research-Urgent Benefits.** Drugs, devices, medical treatments or procedures that are otherwise excluded as Experimental or Investigational but meet the criteria for Research-Urgent benefits as provided in the General Definitions section. No benefits shall be available under this section for any Research-Urgent drug, device, medical treatment or procedure (or related services) that are provided free of charge to trial participants or for any Research-Urgent drug, device, medical treatment or procedure that are excluded by another provision of this Certificate.

3. **Penile Prosthesis for Physiological Impotence.**

Benefits are provided for a penile prosthesis required for physiological (not psychological) impotence, subject to advance approval by the Company only in the following situations: trauma, radical pelvic surgery, diabetes, Peyronie's Disease, vascular or neurological diseases when individual situation warrants coverage in the Company's opinion.

To request advance approval, a written report prepared by Your Doctor must be submitted to the Company. The Company has the right to request and obtain medical information it considers needed to determine whether benefits should be approved or not.

Benefits are not provided for services of sleep laboratories for nocturnal penile tumescence testing.

4. **Home Health Care and Private Duty Nursing Services**

Covered Home Health Care services include services provided by a Medicare certified Home Health Agency.

An Insured must be homebound for the following services to be eligible. An Insured will be considered to be homebound if they have a condition due to illness or injury for which leaving the home is medically contraindicated. The Company has the right to determine whether the patient is homebound.

All Home Health Care and Private Duty Nursing services require Prior Authorization by the Company in order to be eligible for benefits. If prior approval is not obtained, the Company has the right to request medical records to review to determine whether services are eligible under this Certificate.

a. Covered Services include:

1. Nursing care provided in the Insured's home by:

- A Registered Nurse
- A Licensed Practical Nurse
- A licensed vocational nurse

2. Services provided in the Insured's home by a Licensed Social Worker.

3. Private Duty Nursing services provided by a state licensed nursing agency or state licensed nurse for Medically Necessary services provided on an hourly basis to a homebound Insured.

b. Covered Services do not include services:

- Provided by a member of the Insured's immediate family;
- Provided by a person who normally lives in the Insured's home; or
- Which are Custodial/Maintenance care. The Company has the right to determine which services are Custodial/Maintenance care.

c. Services that do not require that the patient be homebound.

- Home care education associated with diabetes, colostomy care, wound care, IV therapy, or any other condition or treatment which the Company has determined is appropriate for home care education, when provided by a Medicare certified Home Health Agency. Benefits for educational services will be limited to no more than three home care education visits per Benefit Period for which home care education is appropriate.
- Home infusion and related services. These services can be provided by either a Medicare certified Home Health Agency, state licensed nursing agency or state licensed nurse.

5. **Hospice Care**

Definitions

a. **Hospice Care Plan** means a coordinated plan of care which provides Palliative Care for the Hospice Patient. This plan is designed to provide care to meet the special needs during the final stages of a terminal illness.

b. **Palliative Care** means treatment directed at controlling pain, relieving other physical and emotional symptoms and focusing on the special needs of the Hospice Patient and the Hospice Patient's Family, as they experience the dying process rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

c. **Hospice Patient's Family** means the Hospice Patient's immediate family, including a spouse, brother, sister, child or parent. Other relations and individuals with significant personal ties to the Hospice Patient may be designated as members of the Hospice Patient's Family by mutual agreement among the Hospice Patient, the relation or individual and the Hospice Team.

d. **Hospice Patient** means a patient diagnosed or referred by a physician, to a Hospice and who alone, or in conjunction with designated family members, has requested and received admission into a hospice program. Written certification by the patient's Doctor that the Hospice Patient has a life expectancy of 6 months or less is required.

e. **Hospice Team or Interdisciplinary Group** means the attending physician and the following hospice personnel: physician, registered or licensed practical nurses, licensed social workers, pastoral or other counselors. Providers of special services, such as mental health, pharmacy, home health aides, trained volunteers and any other appropriate allied health services shall also be included on the Interdisciplinary Group as the needs of the patient dictate.

Election of Hospice Benefits

In order for You to receive Hospice benefits for the covered services listed below, the Company must receive a copy of a hospice election form and the informed consent form from a Medicare certified Hospice. If these forms are not received, benefits of this Hospice Care provision will not be available and services You receive will be processed according to the benefits and limitations of this Certificate other than those listed in this Hospice Care provision.

All Hospice Care services require prior authorization by the Company in order to be eligible for benefits. If prior approval is not obtained, the Company has the right to request medical records for review to determine whether services are eligible under this Certificate.

Eligibility of Services

a. Once Hospice benefits are elected, coverage for the terminal illness and related conditions is limited to the coverage listed in this Hospice Care provision unless specified otherwise.

b. Coverage under this Hospice Care provision is available only for Palliative Care. If Blue Cross and Blue Shield of Kansas determines the care provided is not Palliative Care, benefits of this Hospice Care provision cease to be available.

c. When covered services are not available from a Hospice provider (for example individual psychotherapy services) and the Insured is referred to another provider of service, benefits are not available under this Hospice Care provision, except as provided under the description of Covered Services.

In situations b. and c. listed above when services are not eligible for benefits under the Hospice Care provision, the services will be processed according to the benefits and limitations of this Certificate other than those listed in this Hospice Care provision.

Covered Services

Covered Hospice Care includes the following services provided by a Medicare certified Hospice (or an Institutional or Professional Provider under the direction of a Medicare certified Hospice and not charging

for services separately from the Hospice). Covered services also include the following when provided for routine home care according to the Hospice Care Plan:

a. Nursing care.
b. Home health aide services.
c. Social work services.
d. Pastoral services.
e. Volunteer support.
f. Bereavement services.
g. Counseling services.
h. Dietary and nutritional counseling/services.
i. All drugs, medical supplies, and equipment related to the terminal illness.
j. Speech therapy.
k. Occupational therapy.
l. Physical therapy.
m. Lab fees.
n. Medical equipment.
o. Educational services.
p. Other services and supplies provided through the Medicare certified Hospice (excluding Inpatient Hospital care and Inpatient or Outpatient physician's visits) recommended by a Doctor.

6. **Human Organ or Human Tissue Transplants.**

Benefits are provided (subject to the prior authorization provision set forth below) for the following human organ transplants:

- Cornea
- Heart
- Heart-lung
- Kidney
- Pancreas
- Liver
- Lung (whole or lobar, single or double)
- Small intestine
- Mulitvisceral transplants

There is no coverage hereunder for any transplant not specifically listed as covered or for supplies or services provided directly for or relative to human organ transplants not specifically listed as covered. No benefits will be provided for multiple organ transplant combinations not listed even when one or more of the organs involved is listed as a covered transplant.

Benefits for a human organ transplant will be available for a live donor (whether or not an Insured), if the recipient is an Insured, unless the donor has other coverage.

NOTE: See Prior Authorization Requirement below.

7. **High-Dose Chemotherapy with Hematopoietic Support (commonly referred to as bone marrow transplant and/or peripheral stem cell transplant).** Benefits are available only when precertified and the treatment particular for the Insured's condition is not Experimental or Investigational.

Benefits will be available for the costs associated with the donor search and acquisition of bone marrow or peripheral stem cells when a related donor is not available.

NOTE: Prior Authorization Requirement for Human Organ or Human Tissue Transplants and High-Dose Chemotherapy with Hematopoietic Support

Human organ and human tissue transplants (except cornea transplants), and high-dose chemotherapy with hematopoietic support, require advance written authorization from the Company.

You or Your Doctor must give written notice to the Company at the time as You become a candidate for a human organ transplant or re-transplant or for the high-dose chemotherapy with hematopoietic support.

The Company has the right to require, request and obtain information from Your Doctors and other health care providers involved in the performance of the transplant or re-transplant or the high-dose

chemotherapy procedure with hematopoietic support, and to determine whether or not to authorize benefits based on such information.

The Company's determination of whether or not to authorize benefits will be based on factors such as (but not limited to):

- Provider and facility qualifications
- Comparative costs of the proposed providers and facility

Notwithstanding any contradictory provisions in this document addressing allowable amounts, the Company reserves the right to limit benefits to the lowest allowable amount including organ or tissue acquisition cost which would be accepted by another facility that contracts with the Company to provide these services. Any balance will be the obligation of the Insured.

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8. **Temporomandibular Joint Dysfunction Syndrome.**

a. **Definitions.** For the purposes of this Certificate, the following terms have these meanings:

(1) Temporomandibular Joint Dysfunction Syndrome (TMJ) means a condition involving misalignment or imbalance in the relationship of the person's lower jaw (mandible) to the upper jaw (maxilla), with related spasm of the muscles of mastication (chewing). In this Certificate the terms Craniomandibular Cervical Pain (CRMP), Craniomandibular Facial Pain (CMFP), or Myofascial Pain Dysfunction Syndrome (MFPD) shall have the same meaning and benefits as Temporomandibular Joint Dysfunction Syndrome.

(2) "Treatment Plan" means Your dentist's written report of recommended treatment.

b. **Benefits for Temporomandibular Joint (TMJ) Dysfunction Syndrome**

To the extent this Certificate provides benefits for office visits, diagnostic dental imaging services, etc. for medical conditions, the following services are also covered under the medical (not dental) coverage of this Certificate, applying appropriate Deductibles, Coinsurances, Copayments/Copays, shared payments:

(1) Only one of the following are eligible for benefits and will be subject to the Home or Office Visit payment provisions:

(a) A clinical evaluation, to include examination, history, ordering of necessary diagnostic procedures (such as radiographs, study models if necessary, muscle testing), evaluation of results and consultation with the patient.

(b) A total diagnostic evaluation including, but not limited to, history, examination, radiographs, study models and a patient consultation.

(2) Diagnostic services, including but not limited to:

- Panoramic radiographs
- Cephalometric radiographs with tracing
- Temporomandibular joint tomography
- Temporomandibular joint arthrography
- Skull series; computerized tomography of temporomandibular joint
- Manual muscle testing procedures; and

One of the following:

- Electromyography of cranial supplied nerves
- Electronic computerized neuromuscular testing
- Oscilloscopic neuromuscular testing

The maximum benefit payment (after application of any payment provisions) will be the Company's allowable amount for conventional electromyography, or neuromuscular-type test.

(3) Non-surgical initial treatment procedures (reversible Phase I) limited to:

(a) Orthopedic repositioning appliances (maxillary or mandibular).

(b) Orthopedic (orthotic) splints (such as nite-guards, biteblocks, bite openers, bite plates, muscle de-programmer).

(c) Physical therapy procedures (limited to transcutaneous electrical nerve stimulators, Galvanic stimulation, ultrasound, diathermy).

(d) Trigger point injections.

These services are subject to the provisions of the Insured's medical benefits program.

Exclusions: benefits do not include:

- Equilibration of occlusion
- Coronoplasty
- Occlusal adjustment
- Slides and/or photographs
- Non-prescription drugs
- Vitamins
- Nutrition supplements
- Stretching and other exercises
- Coolant sprays
- Rental or purchase of transcutaneous electrical nerve stimulators
- Office visits
- Periapical, bitewing and full-mouth radiographs
- Moist heat therapy
- Hot packs
- Massage, either manual or by machine
- Acupuncture
- Cold packs
- Range of motion treatments
- Diet survey
- Nutrition counseling
- Orthodontic treatment, including both fixed and removable appliances used for the purpose of moving teeth

(4) Surgical procedures, subject to the appropriate Deductible, Coinsurance, Copayment/Copay, and shared payments of this Certificate, must be prior authorized by the Company based on a Treatment Plan. Requests for authorization will be reviewed based on: diagnosis (the condition must be treatable by surgery); the patient's age; presence of debilitating pain; efficacy of conservative treatment; diagnostic records and description of the proposed surgical procedure.

(5) Final stabilization non-surgical (Irreversible Phase II) treatment.

Benefits for Phase II services, such as appliances, crowns and replacement of missing teeth, may be covered under Your Dental Care Program. If You do not have a Dental Care Program, there are no benefits for these services.

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PRESCRIPTION DRUG PROGRAM

A. General

1. Benefits of the Prescription Drug Program apply to Insureds enrolled for such coverage under the Certificate.
2. **Company Not Liable.** The Company will not be liable for any acts or wrongs of any party related to the sales, compounding, dispensing, manufacturing, or use of any Prescription Drug or insulin. This includes any claim, injury, demand, or judgment based on tort or other grounds (including warranty of merchantability).
3. **Your Pharmacy.** You have the right to select Your own Pharmacy. However, the Company does not guarantee the availability of any drug or supply and does not itself furnish Prescription Drugs. Also, coverage may be limited or unavailable for certain Pharmacies or Specialty Pharmacies as provided below.

B. Definitions

1. **Brand** means a Prescription Drug that is or has been marketed under patent protection.
2. **Compound** means a Prescription Drug: a) that is manufactured by a Pharmacy when no suitable commercial alternative is available; b) for which the main active ingredient is a covered Prescription Drug; and c) for which the purpose is solely to prepare a dose form that is Medically Necessary.
3. **Copayment** means the portion of the charge for a covered Prescription Drug You are responsible for each time Your Prescription Order is filled or refilled.
4. **Diabetic Supplies** means syringes, needles, lancets, test strips and solutions, calibration strips, solutions, and insulin pump supplies used exclusively with diabetic management.
5. **Formulary** means a list of both Brand and Generic Prescription Drugs reviewed and updated by the Pharmacy Benefit Manager and Therapeutics Committee which is comprised of physicians and Pharmacists. Prescription Drugs are selected for inclusion on the Formulary based on safety, efficacy and cost effectiveness. The Formulary is subject to periodic review and modification.

   The Formulary applies only to Prescription Drugs covered under this Program. The Formulary does not apply to Inpatient medications or to medications administered by a Professional Provider. The level of benefits You receive under this Program will be affected by a Prescription Drug's Generic/Brand status on the Formulary.

   To access the Formulary, visit our website at www.bcbsks.com or call Customer Service at the telephone number listed on Your Identification Card.
6. **Generic** means a Prescription Drug that: a) is equivalent to a Brand Drug, b) is available after the patent on that Brand Drug has expired and c) is available from more than one source. Equivalent means therapeutic equivalent as determined by the U.S. Food and Drug Administration.
7. **Pharmacist** means a person registered or licensed under his or her State's laws to dispense Prescription Drugs and/or administer vaccines and immunizations.
8. **Pharmacy** means an establishment registered or licensed where Prescription Drugs are dispensed by a Pharmacist. Pharmacies are further classified as:
   a. **Contracting Pharmacy** means a Pharmacy which has entered into a written network participation agreement with Blue Cross and Blue Shield of Kansas and/or a Pharmacy Benefit Manager.
   b. **Contracting Specialty Pharmacy** means a Contracting Pharmacy which has entered into a written network participation agreement with Blue Cross and Blue Shield of Kansas and/or a Pharmacy Benefit Manager to provide Specialty Prescription Drugs.
   c. **Non-Contracting Pharmacy** means a Pharmacy which has not entered into a written network participation agreement with Blue Cross and Blue Shield of Kansas or a Pharmacy Benefit Manager.
9. **Pharmacy Benefit Manager (PBM)** means an entity with which Blue Cross and Blue Shield of Kansas contracts for the provision of administrative, utilization review and network services for the covered drug and supplies under this Program.
10. **Prescription Drug** means a drug approved for general use in the United States by the U.S. Food and Drug Administration, assigned a National Drug Code (NDC) number and dispensed in compliance with federal or state laws pursuant to a Prescription Order or refill.
11. **Prescription Order** means the request Your Doctor may legally issue for a Prescription Drug.
12. **Prior Authorization** is the process of obtaining approval for certain Prescription Drugs based on criteria established by the Company. Prior Authorization is required for some Prescription Drugs covered under this

Program. Prescription Drugs requiring Prior Authorization are listed on the Formulary. Prescription Drugs may be added or deleted from the list on a quarterly basis.

13. **Specialty Prescription Drug** means Prescription Drugs or classes of Prescription Drugs that are designated by the Company as Specialty Drugs. These include, but are not limited to, drugs that are self-administered by injection, inhaled or taken orally; drugs that may require special handling and storage; drugs that may require strict compliance and patient support; and drugs that may be available through limited distribution arrangements. The list of Specialty Prescription Drugs is on the Formulary.
14. **Utilization Review** means a claims review process of medical necessity. It includes the review of the medical need for prescription and quantity prescribed and the Prescription Orders to verify that Prescription Drugs were dispensed as ordered.

C. Amount of Benefits

The Copayment amounts are:

Insulin	$15.00
Generic Prescription Drug	$15.00
Brand Formulary Prescription Drug	$30.00
Brand Non-Formulary Prescription Drug	$45.00
Compound Prescription Drug	$45.00

Preventive Immunizations (as described in Preventive Health Benefits in the Comprehensive Program section of this document) are paid at 100% of the allowable charge when received from a Network Provider.

Annual Out-of-Pocket Maximum: The Annual Out-of-Pocket Maximum in the Comprehensive Program section is applicable to Prescription Drug benefits. Out-of-Pocket expenses include the Deductible, Coinsurance and/or Copayment provisions under the Comprehensive Program and Prescription Drug Program.

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D. Covered Services

Except as limited, Prescription Drugs are covered when ordered by Your Doctor and dispensed by a Pharmacy based on a Prescription Order.

The covered Prescription Drug services include:

1. The filling of the initial Prescription Order.
2. Refills of the Prescription Order as authorized by Your Doctor within one year from the date of the initial Prescription Order but not before at least two-thirds (2/3) of the previously purchased supply has been exhausted. Authorization for an early refill to accommodate a vacation supply may be obtained by contacting the Company, but not more often than two times per Insured during any 12-month period.
3. The reissue of a Prescription Order by Your Doctor for a medication previously ordered, but not before at least two-thirds (2/3) of the previously purchased supply has been exhausted. Authorization for an early reissue to accommodate a vacation supply may be obtained by contacting the Company, but not more often than two times per Insured during any 12-month period.

Limitations:

a. The benefit for Prescription Drugs pursuant to a Prescription Order shall be limited to a supply sufficient for 34 consecutive days of therapy based on criteria established by the Company, except Prescription Drugs designated by the Company, that are prescribed for certain chronic conditions, may be dispensed in supplies up to a maximum of 100-unit dose quantities, but not to exceed a supply sufficient for 100 consecutive days of therapy, if such is greater than a 34 consecutive day supply.

b. Prior Authorization is required for some Prescription Drugs covered under this Program.

c. A Pharmacy is not required to fill a Prescription Order which in the Pharmacist's judgment should not be filled.

d. Coverage for Specialty Prescription Drugs will be limited to a supply sufficient for 34 consecutive days of therapy. These Prescription Drugs are listed on the Formulary. A list of these Prescription Drugs may also be obtained by contacting Customer Service at the number listed on Your Identification Card. Prescription Drugs may be added or deleted from the list on a quarterly basis.

e. Some excluded Prescription Drugs are listed on the Formulary. These exclusions are in addition to drugs or classes of drugs excluded under other provisions of this Certificate.

4. Growth hormone therapy is covered only under one of the following circumstances:

If under age 18 and diagnosed with:

a. Both laboratory proven growth hormone deficiency or insufficiency and significant growth retardation; or

b. Substantiated Turner's Syndrome, Prader-Willi Syndrome, or Noonan's Syndrome with significant growth retardation; or

c. Chronic renal insufficiency and end stage renal disease with significant growth retardation prior to successful transplantation; or

d. Panhypopituitarism; or

e. Neonatal hypoglycemia related to growth hormone deficiency.

If age 18 and over with:

a. Evidence of pituitary or hypothalamic disease or injury and laboratory proven growth hormone deficiency; or

b. A history of prior growth hormone therapy for growth hormone deficiency or insufficiency in childhood and laboratory confirmation of continued growth hormone deficiency.

Children, Adolescents and Adults:

a. AIDS wasting syndrome

b. Short bowel syndrome

c. Severe burn patients

5. Diabetic Supplies and Insulin

6. Oral Anticancer Medication used to kill or slow the growth of cancerous cells. Such medication is covered at 100 percent of the allowable charge.

7. Psychotherapeutic drugs used for the treatment of Mental Illness and Substance Use Disorders under terms and conditions not less favorable than coverage provided for other Prescription Drugs.

8. Generic oral contraceptives will be covered at 100%.

9. Off-label Prescription Drugs used for the treatment of cancer.

E. Payment of Benefits

Subject to the payment provisions of this Prescription Drug Program, benefits are based on the following allowable charges:

1. **Contracting Pharmacies** -- The allowable charge for a covered Prescription Drug is established under the applicable network participation agreement. The allowable charge minus the Copayment will be paid directly to the Pharmacy.

2. **Non-Contracting Pharmacies** -- The allowable charge is the lesser of the Pharmacy's actual charge for the covered Prescription Drug or the allowable charge had the order been filled by a Contracting Pharmacy. You are responsible for the Copayment and any difference between the actual charge and the allowable charge.

Benefits will be paid to the Insured. Such benefits are personal to that Insured and cannot be assigned to any other person or entity.

NOTE: If You obtain a Prescription Drug from a Contracting Pharmacy and do not, at that time, notify the Pharmacy that You are eligible for Prescription Drug benefits through this Program the Prescription will be considered as having been provided by a Non-Contracting Pharmacy.

F. Exclusions

Benefits are not provided for:

1. Prescription Drugs for which normally (in professional practice) there is no charge.

2. Prescription Drugs for other than human use.

3. Orthopedic or prosthetic appliances and devices.

4. Prescription Drugs purchased from an institutional pharmacy for use while the Insured is an Inpatient in that institution.

5. Charges for delivering any drugs.
6. Any drug prescribed or dispensed in a manner that does not agree with generally accepted medical or pharmaceutical practices.
7. Drugs, supplies, and equipment used in intravenous treatment.
8. Benefits are not available to the extent a Prescription Drug has been covered under another contract, certificate, or rider issued by Blue Cross and Blue Shield of Kansas.
9. Allergy antigens.
10. Any food item, including breast milk, formulas and other nutritional products.
11. Total parenteral nutrition.
12. Drugs available over-the-counter in the equivalent dose which do not require a Prescription Order under federal or state law except those covered under the Preventive Health Benefits section.
13. Charges for services that are not listed as covered services.
14. Services for injuries or diseases related to Your employment to the extent You are covered or are required to be covered by a worker's compensation law. If You enter into a settlement giving up Your right to recover past or future medical benefits under a worker's compensation law, the Company will not pay past or future medical benefits that are the subject of or related to that settlement.

    In addition, if You are covered by a worker's compensation program which limits benefits when other than specified providers are used, and You receive services from a provider not specified by the program, the Company will not pay balances of charges from such non-specified providers after Your benefits under the program are exhausted.
15. Services in which duplicate benefits are available under federal, state, local laws, regulations or programs. Examples of such programs are: Medicare; TRICARE; services in any veteran's facility when the services are eligible for coverage by the government. This Certificate will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid.

    This exclusion applies whether or not You choose to waive Your rights to these services except for those services that would be eligible for benefits under Medicare Part D prescription drug coverage. Such benefits shall only be excluded if You are enrolled in Part D.
16. Any service provided through a district pursuant to an Individual Education Plan (IEP) as required under any federal or state law. This exclusion applies whether or not You choose to waive Your rights to these services.
17. Health services associated with accidental bodily injuries arising from a motor vehicle accident to the extent such services are payable under medical expense payment provision of any automobile insurance policy.
18. Services not prescribed by a Doctor or continued after a Doctor has advised that further care is not necessary.
19. Services that are not Medically Necessary, as defined in this Certificate.
20. Prescription Drugs utilized primarily for stimulation of hair growth. This exclusion applies even if the drug is prescribed for purposes other than the stimulation of hair growth.
21. Charges for completion of insurance claim forms.
22. Any drug, device or medical treatment or procedure and related services that are, as of the date of service, Experimental or Investigational as defined in the General Definitions section. This exclusion does not apply to routine patient care services (as defined in Kansas Administrative Regulation 40-4-43) provided in an approved cancer clinical trial for which benefits would otherwise be available for the same services when not provided in connection with such clinical trial.
23. Services provided directly for or relative to diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion, or aggression.
24. Any drug or supply associated with the medical management and treatment of obesity. This includes, but is not limited to, nutrients and Prescription Drugs prescribed for purposes other than the treatment of obesity.
25. Appetite suppressants.
26. Any service or supply provided or obtained relative to an excluded service. "Provided relative to" refers to any service or supply which would not have been provided or obtained if the excluded service would

not have been provided and which is provided on whether an Inpatient or Outpatient basis by any Eligible Provider.

27. Growth hormone therapy or other drugs used to treat growth failure except in those situations specifically set out as eligible for benefits.
28. Certain Prescription Drugs that have therapeutically equivalent or interchangeable drugs that are available over the counter (OTC) and may be obtained without a Prescription Order. This would include drug products from the same therapeutic class containing different chemical entities, but which would provide similar effects or the same pharmacological action when administered in therapeutically equivalent doses. These drugs are listed on the Formulary.
29. Prescription Drugs listed as excluded on the Formulary. Such exclusions are in addition to drugs or classes of drugs excluded under other provisions of this Certificate.

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MAIL ORDER PRESCRIPTION DRUG PROGRAM

A. General

The Company has contracted with a Mail Order Pharmacy to make available to eligible Insureds, Prescription Drugs subject to the provisions of this Mail Order Prescription Drug Program. The benefits specified in this Mail Order Prescription Drug Program are only applicable to Prescription Drugs ordered through the Mail Order Pharmacy. Nothing in this Mail Order Prescription Drug Program requires You to utilize the Mail Order Pharmacy when filling an order for a Prescription Drug.

NOTE: All products may not be available from the Mail Order Pharmacy. The Mail Order Pharmacy may determine that certain Prescription Drugs will not be dispensed by the Mail Order Pharmacy when the product cannot be safely delivered to the Insured's home, the product is not available to the Pharmacy or the product is not commercially available.

B. Definitions

1. **Brand** means a Prescription Drug that is or has been marketed under patent protection.
2. **Compound** means a Prescription Drug: a) that is manufactured by a Pharmacy when no suitable commercial alternative is available, b) for which the main active ingredient is a covered Prescription Drug and c) for which the purpose is solely to prepare a dose form that is Medically Necessary.
3. **Copayment** means the portion of the charge for a covered Prescription Drug You are responsible for each time Your Prescription Order is filled or refilled through the Mail Order Pharmacy. . The amount of Copayment is determined by whether the order is filled with a Generic or with a Brand Drug.
4. **Diabetic Supplies** means syringes, needles, lancets, test strips and solutions, calibration strips, solutions, and insulin pump supplies used exclusively with diabetic management.
5. **Formulary** means a list of both Brand and Generic Prescription Drugs reviewed and updated by the Pharmacy Benefit Manager and Therapeutics Committee which is comprised of physicians and Pharmacists. Prescription Drugs are selected for inclusion on the Formulary based on safety, efficacy and cost effectiveness. The Formulary is subject to periodic review and modification.

   The Formulary applies only to Prescription Drugs covered under this Program. The Formulary does not apply to Inpatient medications or to medications administered by a Professional Provider. The level of benefits You receive under this Program will be affected by a Prescription Drug's Generic/Brand status on the Formulary.

   To access the Formulary, visit our website at www.bcbsks.com or call Customer Service at the telephone number listed on Your Identification Card.
6. **Generic** means a Prescription Drug that: a) is equivalent to a Brand Drug, b) is available after the patent on that Brand Drug has expired and c) is available from more than one source. Equivalent means therapeutic equivalent as determined by the U.S. Food and Drug Administration.
7. **Mail Order Pharmacy** means an establishment that is registered or licensed in the state in which it is domiciled, from which Prescription Drugs are dispensed by a Pharmacist, which has entered into a written agreement to provide Prescription Drugs to Insureds of Blue Cross and Blue Shield of Kansas who are eligible under this Program, and which has been separately identified to Insureds in a directory or through some other means. The Mail Order Pharmacy, after receiving and processing Your Prescription Order, will deliver the Prescription Drugs through a parcel delivery service company.
8. **Pharmacist** means a person registered or licensed under his or her State's laws to dispense Prescription Drugs.
9. **Pharmacy Benefit Manager (PBM)** means an entity with which Blue Cross and Blue Shield of Kansas contracts for the provision of administrative, utilization review and network services for the covered drug and supplies under this Program.
10. **Prescription Drug** means a drug approved for general use in the United States by the U.S. Food and Drug Administration, assigned a National Drug Code (NDC) number and dispensed in compliance with federal or state laws pursuant to a Prescription Order or refill.
11. **Prescription Order** means the request Your Doctor may legally issue for a Prescription Drug.
12. **Prior Authorization** is the process of obtaining approval for certain Prescription Drugs based on criteria established by the Company. Prior Authorization is required for some Prescription Drugs covered under this Program. Prescription Drugs requiring Prior Authorization are listed on the Formulary. Prescription Drugs may be added or deleted from the list on a quarterly basis.
13. **Utilization Review** means a claims review process of medical necessity. It includes the review of the medical need for prescription and quantity prescribed and the Prescription Orders to verify that Prescription Drugs were dispensed as ordered.

C. Amount of Benefits

The Copayment amounts are:

Generic Prescription Drug $37.50

Brand Formulary Prescription Drug $75.00

Brand Non-Formulary Prescription Drug $112.50

Compound Prescription Drug $112.50

Annual Out-of-Pocket Maximum: The Annual Out-of-Pocket Maximum in the Comprehensive Program section is applicable to Prescription Drug benefits. Out-of-Pocket expenses include the Deductible, Coinsurance and/or Copayment provisions under the Comprehensive Program, Prescription Drug Program and Mail Order Pharmacy Program.

D. Covered Services

Except as limited, Prescription Drugs are covered when ordered by Your Doctor for a condition You have consulted Your Doctor about, dispensed by the Mail Order Pharmacy based on a Prescription Order, and Medically Necessary.

1. The covered Prescription Drug services include:
   a. The filling of the initial Prescription Order.
   b. Refills of the Prescription Order as authorized by Your Doctor within one year from the date of the initial Prescription Order but not before at least two thirds (2/3) of the previously purchased supply has been exhausted. Authorization for an early refill to accommodate a vacation supply may be obtained by contacting the Company, but not more often than two times per Insured during any 12-month period.
   c. The reissue of a Prescription Order by Your Doctor for a medication previously ordered, but not before at least two-thirds (2/3) of the previously purchased supply has been exhausted. Authorization for an early reissue to accommodate a vacation supply may be obtained by contacting the Company, but not more often than two times per Insured during any 12-month period.
   d. **Limitations:**
      (1) The benefit for Prescription Drugs pursuant to a Prescription Order filled through the Mail Order Pharmacy shall be limited to a supply sufficient for 90 consecutive days of therapy based on criteria established by the Company.
      (2) Prior Authorization is required for some Prescription Drugs covered under this Program.
      (3) A Pharmacy is not required to fill a Prescription Order which in the Pharmacist's judgment should not be filled.
      (4) Some excluded Prescription Drugs are listed on the Formulary. These exclusions are in addition to drugs or classes of drugs excluded under other provisions of this Certificate.
2. Growth hormone therapy is covered only under one of the following circumstances:

   If under age 18 and diagnosed with:

   a. Both laboratory proven growth hormone deficiency or insufficiency and significant growth retardation; or
   b. Substantiated Turner's Syndrome, Prader-Willi Syndrome, or Noonan's Syndrome with significant growth retardation; or
   c. Chronic renal insufficiency and end stage renal disease with significant growth retardation prior to successful transplantation; or
   d. Panhypopituitarism; or
   e. Neonatal hypoglycemia related to growth hormone deficiency.

   If age 18 and over with:

   a. Evidence of pituitary or hypothalamic disease or injury and laboratory proven growth hormone deficiency; or
   b. A history of prior growth hormone therapy for growth hormone deficiency or insufficiency in childhood and laboratory confirmation of continued growth hormone deficiency.

   Children, Adolescents and Adults:

   a. AIDS wasting syndrome
   b. Short bowel syndrome
   c. Severe burn patients

3. Diabetic Supplies and Insulin
4. Oral Anticancer Medication used to kill or slow the growth of cancerous cells. Such medication is covered at 100 percent of the allowable charge.
5. Psychotherapeutic drugs used for the treatment of Mental Illness and Substance Use Disorders under terms and conditions not less favorable than coverage provided for other Prescription Drugs.
6. Generic oral contraceptives will be covered at 100%.
7. Off-label Prescription Drugs used for the treatment of cancer.

E. Payment of Benefits

Subject to the Copayment above, Your benefits are based on the following allowable charges:

Mail Order Pharmacy -- The allowable charge for a covered Prescription Drug is as provided for in the Mail Order Pharmacy Agreement.

F. Exclusions

Benefits are not provided for:

1. Prescription Drugs for which normally (in professional practice) there is no charge.
2. Prescription Drugs for other than human use.
3. Orthopedic or prosthetic appliances and devices.
4. Contraceptive devices; therapeutic devices; artificial appliances; hypodermic needles; syringes or similar devices. This exclusion applies regardless of the intended use.
5. Prescription Drugs purchased from other than the Mail Order Pharmacy which is contracting with the Company to provide Prescription Drugs to Insureds under this program. This exclusion applies only to benefits under the Mail Order Prescription Drug Program. Claims for Prescription Drugs obtained via mail order from a pharmacy other than a contracting Mail Order Pharmacy shall be subject to the benefits of the Prescription Drug Program.
6. Charges for delivering any drugs.
7. A drug approved for experimental use.
8. Any drug prescribed or dispensed in a manner that does not agree with generally accepted medical or pharmaceutical practices.
9. Drugs, supplies, and equipment used in intravenous treatment.
10. Benefits are not available to the extent a Prescription Drug has been covered under another contract, certificate, or rider issued by Blue Cross and Blue Shield of Kansas.
11. Allergy antigens.
12. Any food item including breast milk, formulas and other nutritional products.
13. Total parenteral nutrition.
14. Drugs available over-the-counter in the equivalent dose which do not require a Prescription Order by federal or state law except those covered under the Preventive Health Benefits section.
15. Charges for services that are not listed as covered services.
16. Services for injuries or diseases related to Your employment to the extent You are covered or are required to be covered by a worker's compensation law. If You enter into a settlement giving up Your right to recover past or future medical benefits under a worker's compensation law, the Company will not pay past or future medical benefits that are the subject of or related to that settlement.

    In addition, if You are covered by a worker's compensation program which limits benefits when other than specified providers are used, and You receive services from a provider not specified by the program, the Company will not pay balances of charges from such non-specified providers after Your benefits under the program are exhausted.
17. Services in which duplicate benefits are available under federal, state, local laws, regulations or programs. Examples of such programs are: Medicare; TRICARE; services in any veteran's facility when the services are eligible for coverage by the government. This Mail Order Prescription Drug Program will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid.

This exclusion applies whether or not You choose to waive Your rights to these services except for those services that would be eligible for benefits under Medicare Part D prescription drug coverage. Such benefits shall only be excluded if You are enrolled in Part D.

18. Any service provided through a district pursuant to an Individual Education Plan (IEP) as required under any federal or state law. This exclusion applies whether or not You choose to waive Your rights to these services.
19. Health services associated with accidental bodily injuries arising from a motor vehicle accident to the extent such services are payable under medical expense payment provision of any automobile insurance policy.
20. Services not prescribed by a Doctor or continued after a Doctor has advised that further care is not necessary.
21. Services that are not Medically Necessary, as defined in this Mail Order Prescription Drug Program.
22. Prescription Drugs utilized primarily for stimulation of hair growth. This exclusion applies even if the drug is prescribed for purposes other than the stimulation of hair growth.
23. Charges for completion of insurance claim forms.
24. Any drug, device or medical treatment or procedure and related services that are, as of the date of service, Experimental or Investigational as defined in the General Definitions section. This exclusion does not apply to routine patient care services (as defined in Kansas Administrative Regulation 40-4-43) provided in an approved cancer clinical trial for which benefits would otherwise be available for the same services when not provided in connection with such clinical trial.
25. Services provided directly for or relative to diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion, or aggression.
26. Any drug or supply associated with the medical management and treatment of obesity. This includes, but is not limited to, nutrients and Prescription Drugs prescribed for purposes other than the treatment of obesity.
27. Appetite suppressants.
28. Any service or supply provided or obtained relative to an excluded service. "Provided relative to" refers to any service or supply which would not have been provided or obtained if the excluded service would not have been provided and which is provided on either an Inpatient or Outpatient basis by any Eligible Provider.
29. Growth hormone therapy or other drugs used to treat growth failure except in those situations specifically set out as eligible for benefits.
30. Certain Prescription Drugs that have therapeutically equivalent or interchangeable drugs that are available over the counter (OTC) and may be obtained without a Prescription Order. This would include drug products from the same therapeutic class containing different chemical entities, but which would provide similar effects or the same pharmacological action when administered in therapeutically equivalent doses. These drugs are listed on the Formulary.
31. Prescription Drugs listed as excluded on the Formulary. Such exclusions are in addition to drugs or classes of drugs excluded under other provisions of this Certificate.
32. Specialty Prescription Drugs.

ALLOWABLE CHARGES

This Section will tell You what the allowable charge for a service is. It may or may not be the same as the actual charge. Inclusion of a service or provider type in the Allowable Charges section below does not imply coverage for such service. See Covered Services to determine the extent of Your coverage.

As used herein, actual charge means the total amount billed by a provider to all parties for a particular service.

A. Contracting Providers of Blue Cross and Blue Shield of Kansas for other than Prescription Drugs or Sleep Studies.

The Contracting Provider Agreement between the provider and the Company sets out the method the Company will use to determine allowable charges for covered services. Contracting Providers have agreed to accept the Company's determination of Your benefits as payment in full for covered services, except that You are responsible for payment of: Deductible, Coinsurance, Copayment/Copay amounts, shared payment amounts, non-covered services, private room charges in excess of the allowable amount stated in Your Certificate, and amounts in excess of any other benefit limitations of Your Certificate.

B. Contracting Providers of Blue Cross and Blue Shield of Kansas for limited services for other than Prescription Drugs or Sleep Studies.

In certain situations, Institutional Providers may be Contracting Providers for only a limited set of services, e.g., chemical dependency treatment or Outpatient treatment of Medical Emergencies and Accidental Injuries. In such cases, such an Institutional Provider will be treated as a Contracting Provider for the purpose of acceptance of allowable charges established by the Company as payment in full, and direct payment of benefits. For services other than the limited set of services identified above, these Institutional Providers will be considered Non-Contracting.

C. Prescription Drugs

The allowable charge is the amount that contracting providers of the Company's Pharmacy Benefit Manager have agreed to as payment in full for covered Prescription Drugs and/or supplies except that You are responsible for payment of any Deductible, Coinsurance or Copayment/Copay amounts.

D. Contracting Providers of Sleep Studies.

1. **Sleep Studies provided within the Company Service Area:**

   a. **Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of Blue Cross and Blue Shield of Kansas that are Accredited by the American Academy of Sleep Medicine (AASM) and/or the Accreditation Commission for Health Care, Inc. (ACHC) and the physicians to be board certified in sleep medicine.**

   The Contracting Provider Agreement between the provider and the Company sets out the method the Company will use to determine allowable charges for covered services. Contracting Providers have agreed to accept the Company's determination of Your benefits as payment in full for covered services, except that You are responsible for payment of: Deductible, Coinsurance, Copayment/Copay amounts, shared payment amounts, non-covered services, private room charges in excess of the allowable amount stated in Your Certificate, and amounts in excess of any other benefit limitations of Your Certificate.

   b. **Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of Blue Cross and Blue Shield of Kansas that are Not Accredited by the American Academy of Sleep Medicine (AASM) and/or the Accreditation Commission for Health Care, Inc. (ACHC) and the physicians to be board certified in sleep medicine.**

   The allowable charge will be the actual charge for covered services up to 60% of the maximum amount allowable to a Contracting Provider that is accredited by the American Academy of Sleep Medicine or Board Certified in Sleep Medicine. Contracting Providers have agreed to accept the Company's determination of Your benefits as payment in full for covered services, except that You are responsible for payment of: Deductible, Coinsurance, Copayment/Copay amounts, shared payment amounts, non-covered services, private room charges in excess of the allowable amount stated in Your Certificate, and amounts in excess of any other benefit limitations of Your Certificate.

2. **Sleep Studies provided outside the Company Service Area:**

   a. **Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Accredited by the American Academy of Sleep Medicine (AASM) and/or the Accreditation Commission for Health Care, Inc. (ACHC) and the physicians to be board certified in sleep medicine.**

   The allowable charge will be the actual charge up to the maximum amount allowable as determined as described in item F.2.a. below.

b. **Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Not Accredited by the American Academy of Sleep Medicine (AASM) and/or the Accreditation Commission for Health Care, Inc. (ACHC) and the physicians to be board certified in sleep medicine.**

The allowable charge will be the actual charge for covered services up to 60% of the maximum amount allowable as determined in F.2.a. below. You will be responsible for the difference between the allowable charge and the maximum amount allowable as determined in item D.2.a. above.

E. Non-Contracting Providers

If You receive services from a provider who has not contracted with Blue Cross and Blue Shield of Kansas or another Blue Cross and Blue Shield Company (for services provided outside the Company Service Area), the allowable charges (before application of any Deductible, Coinsurance, Copayment/Copay, shared payment or benefit limits called for by Your Certificate) will be determined as follows and You are responsible for any difference between the allowable charge and the actual charge. As used in this section, "Contracting" means contracting with Blue Cross and Blue Shield of Kansas.

When a covered service that is required for a Medical Emergency is provided by a Non-Contracting Provider, the allowable charge will be the actual charge for the service up to the maximum amount allowable for the same service provided by providers that are Contracting Institutional Providers of the Company that are the same kinds of providers or Contracting Professional Providers of the Company with the same licensure or certification.

"Same service" as used in this Section E shall be determined on the basis of the intended result of the service and not the technical methodology used by the provider to perform that service.

All reimbursement identified in this Section E is paid according to the cost-containment policies and procedures applicable to Contracting Providers. If You receive services from a Non-Contracting Provider, You will be responsible for payment for services for which payment is not made by the Company due to a cost-containment policy or procedure applicable to a Contracting Provider of the same licensure providing the same service. Such cost-containment policies include, but are not limited to, determinations by the Company that the services provided are of such a nature that they should be considered one service with a single payment, or that the billing for service inappropriately categorized the nature of the services performed, in the opinion of the Company, and payment should be made for a different type or different intensity of service.

1. **General Acute Care and Special Hospitals**

a. **Inpatient Services**

(1) **General Acute Care (Full-Service) Hospitals** -- The allowable charge for Inpatient services will be the lesser of:

(a) the actual charge; or

(b) 80% of the prior calendar year's average allowed charge per day (sum of allowed charges divided by sum of Inpatient days) for Contracting facilities in the same Peer Group (as designated below); or

(c) 80% of the prior calendar year's average allowed charge per day for all Contracting General Acute Care Hospitals in Kansas.

For purposes of this provision, "General Acute Care Hospitals" are defined as those Hospitals providing 24-hour emergency care, as well as a wide range of other medical services.

For purposes of this provision, "Peer Group Designations" are as follows:

Peer Group Designations

1 = Hospitals with less than 50 beds

2 = Hospitals with 51-99 beds

3 = Hospitals with more than 100 beds (excluding Topeka and Wichita)

4 = Topeka Hospitals

5 = Wichita Hospitals

(2) **Special Hospitals --** The allowable charge for Inpatient services will be the lesser of:

(a) the actual charge; or

(b) 80% of the prior calendar year's average allowed charge per day (sum of allowed charges divided by sum of Inpatient days) for all Contracting Special Hospitals of the Company.

For purposes of this provision, "Special Hospitals" are defined as those Hospitals which are primarily or exclusively engaged in the care and treatment of patients with specified medical conditions, including cardiac, orthopedic, or surgical patients.

b. **Outpatient Services** -- The Outpatient services allowable charge will be the lesser of:

(1) the actual charge; or

(2) 80% of the current year's lowest maximum amount allowable used for all Contracting Institutional Providers.

If a maximum amount allowable has not been set for services provided on an Outpatient basis, the allowable charge will be 80% of the actual charge. If no Contracting Provider provides the same service, the Company will determine an amount to be allowed for the procedure at its discretion.

2. **All Other Hospitals and Ambulatory Surgical Centers**

The allowable charge will be the lesser of:

a. the actual charge; or

b. 80% of the maximum amount allowable for a Contracting Provider for the same service.

If no Contracting Provider provides the same service, the Company will determine an amount to be allowed for the procedure at its discretion.

3. **Medical Care Facilities --** The allowable charge is the actual charge for covered services up to 80% of the maximum amount allowable for a Medical Care Facility that is a Contracting Provider.

4. **Ambulance Service --** The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable for the ambulance service had it been provided by a Contracting Provider of ambulance service under similar circumstances.

5. **Doctors of Medicine, Doctors of Osteopathy, Dentists, Optometrist, Chiropractors, Podiatrists or Certified Psychologists --** The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable for the same procedure by providers that are Contracting Providers of the Company with the same licensure or certification. If no Contracting Providers provide the same service, the Company will determine an amount to be allowed for the procedure.

6. **Private Duty Nursing, Home Health Care, Hospice, Medical Supplies, Orthopedic Appliances, Prostheses, and Other Services that may be covered by Your Certificate --** The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable for the same service by providers that are Contracting Providers of the Company with the same licensure or certification.

7. **Sleep Studies**

a. **Sleep Studies provided within the Company Service Area:**

1. **Non-Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of Blue Cross and Blue Shield of Kansas that are Accredited by the American Academy of Sleep Medicine (AASM) or Non-Contracting Professional Providers of Blue Cross and Blue Shield of Kansas that are Board Certified in Sleep Medicine**

The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable as determined in item D.1.a. above.

2. **Non-Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of Blue Cross and Blue Shield of Kansas that are Not Accredited by the American Academy of Sleep Medicine (AASM) or Non-Contracting Professional Providers of Blue Cross and Blue Shield of Kansas that are Not Board Certified in Sleep Medicine**

The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable as determined in item D.1.b. above.

b. **Sleep Studies provided outside the Company Service Area:**

1. **Non-Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Accredited by the American Academy of Sleep Medicine (AASM) or Non-Contracting Professional Providers of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Board Certified in Sleep Medicine**

The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable as determined in item D.2.a. above.

2. **Non-Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Not Accredited by the American Academy of Sleep Medicine (AASM) or Non-Contracting Professional Providers of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Not Board Certified in Sleep Medicine**

   The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable as determined in item D.2.b. above.

8. **Dentists**

   a. **Dental Services provided within the Company Service Area:**

   The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable for the same procedure by dentists that are Contracting Providers of the Company with the same licensure or certification. If no Contracting Providers provide the same service, the Company will determine an amount to be allowed for the procedure in its discretion.

   b. **Dental Services provided outside the Company Service Area:**

   The allowable charge is the smaller of: the actual charge for the service or the maximum allowable charge for the service as determined by the Company.

F. Out-of-Area Services

1. **In areas where the Company offers contracting provider status directly or through arrangements to a class or classes of providers (such as Hospitals and/or physicians):**

   a. When a provider in such class contracts with the Company, the provisions in Section A apply.

   b. When a provider in such class does not contract with the Company, the provisions in Section E apply.

2. **For out-of-area arrangements other than those set forth in item F. 1:**

   Blue Cross and Blue Shield of Kansas has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever You obtain healthcare services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees.

   Typically, when accessing care outside our service area, You will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, You may obtain care from non-participating healthcare providers. Our payment practices in both instances are described or referenced below.

   a. **BlueCard Program (not applicable to Sleep Studies and Dental Services not associated with Accidental Injuries)**

   Under the BlueCard Program, when You access covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

   Whenever You access covered healthcare services outside our service area and the claim is processed through the BlueCard Program, the amount You pay for covered healthcare services is calculated based on the lower of:

   - The billed covered charges for Your covered services; or
   - The negotiated price that the Host Blue makes available to us.

   Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with Your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

   Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for Your claim because they will not be applied retroactively to claims already paid.

   Federal law or laws of a small number of states may require the Host Blue to add a surcharge to Your calculation. If any federal law or the state laws mandate other liability calculation methods, including a

surcharge, we would then calculate Your liability for any covered healthcare services according to applicable law.

If You receive covered healthcare services under a Value-Based Program inside a Host Blue's service area, You will not bear any portion of provider incentives, risk sharing, and/or care coordination fees of such arrangement, except when a Host Blue passes those fees to us through average pricing, or fee schedule incentive adjustments. Value-Based Program means an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality factors and is reflected in provider payment.

b. **Non-Participating Healthcare Providers Outside the Blue Cross and Blue Shield of Kansas Service Area - See Section E, Non-Contracting Providers, above.**

GENERAL EXCLUSIONS

The following General Exclusions apply to all Your coverages described in this Certificate. Additional limitations and exclusions that apply to specific benefits may be found within the description of such benefits.

A. Benefits will not be provided for:

1. Services that are not listed as covered services.
2. Services for injuries or diseases related to Your employment to the extent You are covered or are required to be covered by a worker's compensation law. If You enter into a settlement giving up Your right to recover past or future medical benefits under a worker's compensation law, the Company will not pay past or future medical benefits that are the subject of or related to that settlement.

   In addition, if You are covered by a worker's compensation program which limits benefits when other than specified providers are used, and You receive services from a non-specified provider not specified by the program, the Company will not pay balances of charges from such non-specified providers after Your benefits under the program are exhausted.
3. Services in which duplicate benefits are available under federal, state, or local laws, regulations or programs. Examples of such programs are: Medicare; TRICARE; services in any veteran's facility when the services are eligible for coverage by the government. This Certificate will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid.

   This exclusion applies whether or not You choose to waive Your rights to these services except for those services that would be eligible for benefits under Medicare Part D prescription drug coverage. Such benefits shall only be excluded if You are enrolled in Part D. Waiving Your rights to these services shall include failure to purchase coverage under any such government programs, including Medicare Parts A and B, when You are eligible to purchase such coverage.
4. Any service provided through a school district pursuant to an Individual Education Plan (IEP) as required under any federal or state law.

   This exclusion applies whether or not You choose to waive Your rights to these services.
5. Services not prescribed by a Doctor or continued after a Doctor has advised that further care is not necessary.
6. Services that are not Medically Necessary, as defined in the Certificate.
7. Services that are determined not to be medically necessary through the hospital's Utilization Review process. In the absence of a hospital Utilization Review process, the Company has the right to determine when services are medically unnecessary.
8. Services provided by Institutional and Professional Providers for unnecessary Inpatient admissions when services and evaluations that could satisfactorily be provided on an Outpatient basis.
9. Any drug, device or medical treatment or procedure and related services that are, as of the date of service, Experimental or Investigational as defined in the General Definitions section. This exclusion does not apply to routine patient care services (as defined in Kansas Administrative Regulation 40-4-43) provided in an approved cancer clinical trial for which benefits would otherwise be available for the same services when not provided in connection with such clinical trial.
10. Procedures and diagnostic tests that are considered to be obsolete by the Company's professional medical-advisory committee.
11. Services provided directly for or relative to diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion, or aggression.
12. Services that are already covered under another provision of this Certificate.
13. Blood or payment to blood donors.
14. Any service or supply associated with the medical management and treatment of obesity. This includes but is not limited to surgery, office visits, hospitalizations, laboratory or radiology services, prescription drugs, medical weight reduction programs, nutrients and diet counseling except for those services covered as Preventive Health Benefits.
15. Inpatient Skilled Care, Intermediate Care, Convalescent Care, Custodial/Maintenance Care or Rest Cures.
16. All services associated with transplant procedures except those specifically set out as benefits.

17. Services associated with any mass screening type of physical or health examination except for pap smears and mammograms performed at a mobile facility certified by the Centers for Medicare and Medicaid Services. Two examples of mass screenings are mobile vans and school testing programs.
18. Autogenic biofeedback services and materials except for urinary incontinence in adults 18 years old and older.
19. Acupuncture.
20. Services or supplies associated with sex changes/gender reassignment, and services related to sexual function, and any related complications.
21. Reversal of sterilization procedures.
22. In vitro fertilization, in vivo fertilization or any other medically-aided insemination procedure.
23. Charges for autopsies, unless the autopsy is requested by Blue Cross and Blue Shield of Kansas.
24. Transportation other than covered Ambulance Services.
25. Charges for completion of insurance claim forms.
26. Laboratory services performed by an independent laboratory that is not approved by Medicare.
27. Prescription drugs utilized primarily for stimulation of hair growth. This exclusion applies even if the drug is prescribed for purposes other than the stimulation of hair growth.
28. Cosmetic or reconstructive surgery except when the surgical procedure is one of the following:
    a. Cosmetic or reconstructive repair of an Accidental Injury.
    b. Reconstructive breast surgery in connection with a Medically Necessary mastectomy that resulted from a medical illness or injury. This includes reconstructive surgery on a breast on which a mastectomy was not performed in order to produce a symmetrical appearance.
    c. Repair of congenital abnormalities and hereditary complications or conditions, limited to:
        (1) Cleft lip or palate.
        (2) Birthmarks on head or neck.
        (3) Webbed fingers or toes.
        (4) Supernumerary fingers or toes.
    d. Reconstructive services performed on structures of the body to improve/restore impairments of bodily function resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

    For purposes of this provision, the term "cosmetic" means procedures and related services performed to reshape structures of the body in order to alter the individual's appearance.
29. Refractive procedures including; radial keratotomies, corneal relaxation, keratophakia, keratomileusis, or any other procedure used to reshape the corneal curvature except for Medically Necessary procedures associated with severe anisometropia.
30. All services associated with Temporomandibular Joint Dysfunction Syndrome except those services specifically set out as benefits.
31. Health services associated with accidental bodily injuries arising from a motor vehicle accident to the extent such services are payable under a medical expense payment provision of any automobile insurance policy. The excluded expenses cannot be used for any purpose under this Certificate.
32. Automatic external defibrillators.
33. Institutional Provider services for personal items such as television, radio, telephone, comfort kits, materials used in occupational therapy, air conditioning provided on an optional basis, or internet access.
34. Professional Provider services or charges for:
    a. Services where the Provider would normally make no charge.
    b. Travel expenses, mileage, time spent traveling, telephone calls, charges for services provided over the telephone, services provided through e-mail or electronic communications. For the purpose of this provision electronic communications means communication other than telemedicine. Telemedicine means the use of telecommunications technology to provide, enhance, or expedite health care services, as by accessing off-site databases, linking clinics or physicians' offices to central hospitals, or transmitting x-rays or other diagnostic images for examination at another site.

c. Services by an immediate relative or member of Your household. "Immediate relative" means the husband or wife, children, parents, brother, sister, or legal guardian of the person who received the service. "Member of Your household" means anyone who lives in the same household and who was claimed by You as a tax deduction for the year during which the service was provided.

d. Repair or replacement of dental plates and all dental care other than that listed as a covered service.

e. Hearing aids; servicing of visual corrective devices, or consultations related to such services; orthoptic and visual training.

35. Any service associated with dental implants, surgical treatment or diagnostic services except as otherwise stated in this Certificate.

36. Educational benefits except for those pertaining to diabetic education, colostomy care, wound care, IV therapy, or any other condition or treatment which the Company has determined is appropriate for home care education.

37. Dental appliances or restorations necessary to increase vertical dimensions or restore the occlusion.

38. Any food item including breast milk, formulas and other nutritional products.

39. Appetite suppressants.

40. Drugs which are available in an equivalent dose over-the-counter and which do not require a Prescription Order by federal or state law.

41. Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders IV(1994) which are not attributable to a mental disorder and are a focus of clinical attention, e.g., marriage counseling. This exclusion applies to all benefits provided by this Certificate; it is not limited to those benefits listed for Mental Illness or Substance Use Disorders.

42. Any service or supply provided or obtained relative to an excluded service. "Provided relative to" refers to any service or supply which would not have been provided or obtained if the excluded service would not have been provided and which is provided on either an Inpatient or Outpatient basis by any Eligible Provider.

43. Diagnostic tests and evaluations are ordered, requested or performed solely for the purpose of resolving issues in the context of legal proceedings, including those concerning custody, visitation, termination of parental rights, civil damages or criminal actions.

44. Services, appliances or restorations for altering vertical dimension for restoring occlusion, for replacing tooth structure lost by attrition or abrasion, bruxism, erosion or abfractions; for aesthetic purposes; splinting or equilibration.

45. Temporary or Provisional dental services and procedures, including, but not limited to, Provisional crowns, Provisional splinting, interim complete or partial dentures. "Provisional" means a service or procedure that is provided for temporary purposes or is used over a limited period; a temporary or interim solution; usually refers to a prosthesis or individual tooth restoration.

46. Dental services and prosthodontic devices that are duplicated in whole or in part, due to the Insured failing to complete the initial treatment plan.

47. Pharmacological agent(s) inserted into a periodontal pocket to suppress pathogenic microbiota.

48. Any device used for enhancing or enabling communication except for an electrolarynx.

49. Services provided for a Mental Illness or Substance Use Disorder by a provider that is not an Eligible Provider for Mental Illness or Substance Use Disorders.

50. Non medical services (including but not limited to legal services, social rehabilitation, educational services, vocational rehabilitation, job placement services).

51. Services of volunteers.

52. Any assessment to attend an alcohol and drug safety action program by a diversion agreement or by court order.

53. Prostheses that require surgical insertion into the body and are billed by an entity or person that is not the Hospital or Ambulatory Surgical Center where the surgery was performed.

54. Services for or related to elective abortions.

For purposes of this provision, "elective" means as follows: for any reason other than to prevent the death of the mother upon whom such services are performed, except that it includes those services based on a claim or diagnosis that the mother shall or may engage in conduct likely to result in her death.

For the purpose of this provision, "abortion" means as follows: the use or prescription of any instrument, medicine, drug, or any other substance or device to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of a child after live birth, or to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma, or physical assault on the pregnant woman or her unborn child and which causes the premature termination of the pregnancy.

Form GE-1018ng 1/14

APPEAL PROCEDURES

A. Purpose. This section outlines the procedures for and the time periods applicable to Claim and Appeal determination decisions for Adverse Decisions. It is the policy of the Company to afford Insureds a full and fair review of Claim decisions and Appeal decisions as a right under applicable federal and state law.

However, an Insured's rights accrued hereunder or under applicable state or federal law (including but not limited to ERISA) are not assignable to any person or entity. Authorized Representatives may be designated as provided in Section B below.

B. Definitions. For the purpose of this Appeal Procedures Section, the following terms and their definitions apply:

1. **Adverse Decision,** for the purposes of these Appeals procedures (and ERISA, as applicable), means a denial in whole or in part of a Pre-Service Claim or a Post-Service Claim and for which You are financially responsible or, for a Pre-Service Claim, for which You would be financially responsible, if You obtained the service. Adverse Decision, for the purposes of External Review procedures, is limited to the definition of Adverse Decision Eligible for External Review. Adverse Decision also means any retroactive cancellation of coverage other than for non-payment of premium.
2. **Adverse Decision Eligible for External Review** means (1) in the case of other than an Emergency Medical Condition, a Claim for a proposed or delivered health care service which would otherwise be covered under this Certificate but for which the Insured has received an Adverse Decision following an Appeal due to the fact that the service is not or was not Medically Necessary or the health care treatment has been determined by the Company to be Experimental or Investigational and the denial leaves the Insured with a financial obligation or prevents the Insured from receiving the requested service, or (2) in the case of an Emergency Medical Condition, a Claim for which an initial Adverse Decision by the Company that a proposed health care service which would otherwise be covered under this Certificate is not Medically Necessary or the health care treatment has been determined by the Company to be Experimental or Investigational and the denial would leave the Insured with a financial obligation or prevents the Insured from receiving the requested service, or (3) a Pre-Service Request for a benefit determination or advance approval a) that is not a Pre-Service Claim; b) which is denied by the Company due to the fact the requested services are not Medically Necessary or are Experimental or Investigational; and c) based upon which You choose not to obtain the requested services. For item (3) above, no Appeals need be submitted to the Company in order for the Adverse Decision to be eligible for External Review. For items (1) and (2) above, the procedure in section D. below applies. Notwithstanding any provision of this Certificate to the contrary, the External Review procedure is not available for dental services.
3. **Appeal** means a written request, except in the case of Urgent Care in which case the request may be submitted orally or in writing, for review of an Adverse Decision that is submitted to the Company by an Insured or the Insured's Authorized Representative.
4. **Authorized Representative** means, for non-urgent care, a person designated by You in writing as authorized to represent them for Appeals as permitted under ERISA. This may only be achieved through use of a form provided by BCBSKS by contacting the Customer Service Center at the telephone number on the back of Your identification card. Any attempt to designate via any other form shall be deemed void and ineffective on its face. For Urgent Care, such written authorization is not required if the Appeal is made on Your behalf by a health care provider with knowledge of Your medical condition.
5. **Claim for Benefits or Claim** means a request for treatment benefit or payment benefits made by an Insured in accordance with the Company's procedure for filing Claims. A Claim includes both Pre-Service Claims and Post-Service Claims. A Claim must have sufficient information upon which to base a decision regarding benefits according to all of the provisions of the Certificate.
6. **Emergency Medical Condition** means:
   a. The sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part or would place a person's health in serious jeopardy;
   b. a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the Insured or would jeopardize the Insured's ability to regain maximum function; or
   c. a medical condition for which coverage has been denied based on a determination that the recommended or requested health care service or treatment is experimental or investigational, if the Insured's treating physician certifies, in writing, that the recommended or requested health care service or treatment for the medical condition would be significantly less effective if not promptly initiated.
7. **ERISA** means the Employee Retirement Income Security Act of 1974. ERISA is a federal law that applies to employer sponsored health benefit plans if the employer is not a government entity or a church organization.

8. **External Review** means the review of an Adverse Decision by an External Review Organization.
9. **External Review Organization** means an entity that conducts independent External Reviews of Adverse Decisions pursuant to a contract with the Kansas Insurance Department.
10. **Pre-Service Claim** means a request for a Claims decision when prior authorization of the services is required by the Company.
11. **Pre-Service Request** means a request for advance information on the Company's possible coverage of items or services or advance approval of covered items or services that do not constitute Pre-Service Claims. Subsequent inquiries regarding the same service or item shall not be considered a Pre-Service Request unless additional substantive clinical information is provided.
12. **Post-Service Claim** means a request for a Claims decision for services that have been provided.
13. **Urgent Care** means care for a condition that delay in receiving such care could seriously jeopardize the life or health of the Insured or the ability of the Insured to regain maximum function or, in the opinion of a physician knowledgeable of the Insured's condition, would subject the Insured to severe pain that could not be adequately managed without care or treatment. In determining whether a Claim involves Urgent Care, the Company must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a physician with knowledge of the Insured's medical condition determines that a Claim involves Urgent Care, the claim must be treated as an Urgent Care Claim.

C. Initial Claim Decisions

The time periods in which the Company must make initial Claim decisions (the first determination of benefits available for an Urgent Care Claim, a Pre-Service Claim or a Post-Service Claim) are as follows:

Action	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Initial Benefit Decision (from the date the Claim is received by the Company)	72 hours	15 days	30 days
Extension (from the date the Claim is received by the Company)	None - Notice requesting additional information due - 24 hours*	30 days*	45 days*

* The time periods listed are those required. An Insured may voluntarily agree to provide the Company additional time within which to make a decision.

Time for Insured to Provide more Information (from the date the information was requested by the Company)	48 hours	45 days	45 days

D. Appeal of Initial Adverse Decisions (including Adverse Decisions Eligible for External Review)

An Insured or the Insured's Authorized Representative has the right to obtain, without charge, copies of documents relating to the Adverse Decision and has the right to appeal an Adverse Decision from an initial Claim decision. This is a first level Appeal.

1. The time periods that apply to first level Appeal decisions are as follows:

Action	Urgent Care Claim	Pre-Service Claim	Post-Service Claim Retroactive Cancellation
Time to File Appeal (from the date of receipt of the Adverse Decision)	180 days	180 days	180 days
Initial Appeal Decision (from the date the Appeal is received by the Company)	72 hours	15 days	30 days
Extension	None*	None*	None*

(from the date the Appeal is received by the Company)

* The time periods listed are those required. An Insured may voluntarily agree to provide the Company additional time within which to make a decision.

2. A first level Appeal will be coordinated by a representative of the Company's Customer Service Center.

E. Procedure for Pursuing an External Review

1. The Insured has the right to request an External Review of an Adverse Decision Eligible for External Review after an Appeal (where applicable) has been completed or when the Insured has not received a final Adverse Decision within 60 days of seeking such review, unless the delay was requested by the Insured. In the case of a request for an External Review of an Adverse Decision Eligible for External Review involving an Emergency Medical Condition, such request may be made before the Insured has exhausted all the other available review procedures. The Company will notify the Insured in writing regarding a final Adverse Decision and of the opportunity to request an External Review.

2. Within four (4) months of receipt of the notice of a final Adverse Decision, the Insured, the treating physician or health care provider acting on behalf of the Insured with written authorization from the Insured, or a legally authorized designee of the Insured must make a written request for an External Review to the Kansas Insurance Commissioner, at the Kansas Insurance Department, 420 SW 9th Street, Topeka, KS 66612, (785) 296-3071 or (800) 432-2484.

3. Within ten (10) business days of receipt of such request (immediately, when the request for External Review involves an Emergency Medical Condition), the Kansas Insurance Commissioner will notify the Insured and other involved parties as to whether the request for External Review is granted.

4. For those requests that qualify for External Review, the External Review Organization will issue a written decision to the Insured and the Kansas Insurance Commissioner within 30 business days. The External Review Organization will issue its written decision within 72 hours when the request for External Review involves an Emergency Medical Condition. The standard of review shall be whether the health care service denied by the Company was Medically Necessary or in the case of reviews regarding Experimental or Investigational treatment, whether the health care service denied by the Company was covered or excluded from coverage under the terms of this Certificate.

5. The decision of the External Review Organization may be reviewed directly by the district court at the request of either the Insured, insurer, or health insurance plan. The review by the district court shall be de novo. The decision of the External Review Organization shall not preclude the Insured, insurer or health insurance plan from exercising other available remedies applicable under state or federal law. Seeking a review by the district court or any other available remedies exercised by the Insured, insurer or health insurance plan after the decision of the External Review Organization will not stay the External Review Organization's decision as to the payment or provision of services to be rendered during the pendency of the review by the insurer or health insurance plan. All material used in an External Review and the decision of the External Review Organization as a result of the External Review shall be deemed admissible in any subsequent litigation.

The right to External Review shall not be construed to change the terms of coverage under this Certificate. In no event shall more than one External Review be available during the same year for any request arising out of the same set of facts.

F. Right to a Judicial Review

You have the right to bring suit (including under ERISA Section 502(a) if applicable) in state or federal court (as appropriate) only after You have exhausted the first level Appeal of an Adverse Decision, whether or not You pursue External Review. However, in the case of an Adverse Decision Eligible for External Review involving an Emergency Medical Condition, no Appeal is necessary and only completion of the External Review process is required in order for the right to bring suit to accrue. In all events, such suit or proceeding must be commenced no later than 5 years after the date from the time written proof of loss is required to be given.

G. Strict Adherence by Company

If for any reason the Company fails to strictly adhere to these appeal procedures as required by state or federal law, the Insured shall be deemed to have exhausted the internal claims and appeals process regardless of whether the Company asserts it substantially complied with appeals procedures or committed any de minimis error.

GENERAL INFORMATION

A. Company's Right to Determine if Services are Medically Necessary: Benefits are available only for medically necessary services. The Company has the right to require information, including medical records, to make this decision.

B. Insured/Provider Relationship: The choice of a provider is solely that of the Insured.

C. The Company's Responsibility is Limited: Institutional Provider services are subject to the rules and regulations of the provider including rules about admissions, discharge and availability of services. The Company does not guarantee that admission or any specific type of room or kind of service will be available.

The Company is obligated to provide benefits for the services of Your Eligible Provider only to the extent provided in this Certificate. The Company does not guarantee the availability of a provider.

The Company shall not be liable for any acts or admissions of any provider of service. This includes negligence, misconduct, malpractice, refusal to provide a service or breach of contract.

D. Your Identification Card: When You receive services, show Your current Identification Card when obtaining services from an Eligible Provider at the provider's office.

E. Your Authorization: By accepting coverage under this Certificate, You permit the Company to request any information related to a claim for services that You received and authorize that any information may be given to the Company regarding medical services You have received. This applies to all types of claims, including claims related to Medicare.

If the Company asks for information and does not receive it, payment for covered services cannot be made. The claim will be processed for payment only when the requested information has been received and reviewed.

F. Notice of Claim: You are responsible for submitting written notice of claim within 20 days after a covered loss begins or as soon as reasonably possible. If Your provider submits written notice on Your behalf within the time period specified above, such notice will satisfy the requirements of this provision. The notice can be given to Blue Cross and Blue Shield of Kansas at its home office, 1133 SW Topeka Boulevard, Topeka, Kansas 66629. Notice should include Your name and Your identification number as stated on Your Identification Card.

G. Claim Forms: The Company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice the claimant shall be deemed to have complied with the claim filing requirements of Your Certificate.

H. Proof of Loss: Written proof of loss must be furnished to the Company at 1133 SW Topeka Boulevard, Topeka, Kansas 66629, in case of claim for loss for which Your Certificate provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the Company is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

I. Time of Payment of Claims: Benefits payable under Your Certificate will be paid immediately upon receipt of proper written proof of loss.

J. Payment of Claims. For covered services received from the following providers:

1. **Contracting Provider of Blue Cross and Blue Shield of Kansas or another entity on behalf of Blue Cross and Blue Shield of Kansas:** Your benefits will be paid directly to the Contracting Provider.
2. **Contracting Provider of Blue Cross and Blue Shield of Kansas for limited services:**

   When You receive services for which the provider is contracting Your benefits will be paid directly to the Contracting Provider.

   When You receive services for which the provider is not contracting Your benefits will be paid directly to You. Such benefits are personal to You and cannot be assigned to any other person or entity.
3. **Non-Contracting Provider in the Company Service Area:** Your benefits will be paid directly to You. Such benefits are personal to You and cannot be assigned to any other person or entity.
4. **Covered Provider in a class of providers that are not offered Contracting Provider status:**

   Your benefits will be paid directly to You, with such benefits being personal to You and not assignable to any other person or entity.
5. **Covered Provider Outside the Company Service Area:**

a. Located in an area where the Company offers contracting provider status, directly or through arrangements with another entity, to the provider from whom service was received:

(1) if the provider is a Contracting Provider, Your benefits will be paid to the provider.

(2) if the provider is a Non-Contracting Provider, Your benefits will be paid directly to You, with such benefits being personal to You and not assignable to any other person or entity.

b. Located in an area where the Company does not offer contracting provider status, either directly or through arrangements with another entity, to the provider from whom service was received:

(1) In instances where the Insured receives service from a provider that is contracting with the Blue Cross and/or Blue Shield Company servicing the area in which the provider is located, payment will be made directly to the provider.

(2) In instances where the Insured receives service from a provider that is not contracting with the Blue Cross and/or Blue Shield Company servicing the area in which the provider is located, Your benefits will be paid directly to You, with such benefits being personal to You and not assignable to any other person or entity.

6. Any benefits unpaid at Your death may be paid to Your estate.

If benefits are payable to Your estate, the Company may pay up to $1,000 to anyone related to You by blood or marriage, whom the Company considers to be entitled to the benefits. The Company will be discharged to the extent of any such payment made in good faith.

K. Physical Examination: The Company, at its expense, has the right to have You examined as often as reasonably necessary while a claim is pending.

L. Legal Actions: No legal action may be brought to recover on Your Certificate within 60 days after written proof of loss has been given as required by Your Certificate. No such action may be brought after 5 years from the time written proof of loss is required to be given.

M. Errors Related to Your Coverage: If the Company's records of Your coverage are in error due to a Company error or delay, the record will be corrected after discovery of the error. If Your premiums are affected, the Company may need to make a retroactive change in Your premiums. The Company will make appropriate changes in Your coverage and/or premiums to ensure that You have the coverage You are entitled to under this Certificate.

The Company has the right to correct benefit payments which are made in error. Providers and/or You have the responsibility to return any overpayments to the Company. The Company has the responsibility to make additional payments if an underpayment is made.

N. Statements Made by the Contract Holder or the Insured: A copy of the application, if any, of the Contract Holder shall be attached to the Contract when issued. All statements made by the Contract Holder or by the Insured will be deemed representations and not warranties. No statement made by an Insured will be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the Insured.

O. Notice

1. **From the Company to the Contract Holder.** A notice sent to the Contract Holder by the Company is considered given when mailed to the Contract Holder's address as it appears in the records of the Company.

2. **From the Company to an Insured.** A notice sent to an Insured by the Company is considered given when mailed to the Insured's address as it appears in the records of the Company.

3. **From the Contract Holder or an Insured to the Company.** Notice to the Company is considered given when received by the Company at 1133 SW Topeka Boulevard, Topeka, Kansas 66629. Any such notice should include the Insured's name and the identification number on the Identification Card.

P. Changes In this Contract: Benefits and premiums may be changed after approval by the Board of Directors of the Company and filing by the Kansas Insurance Commissioner.

No agent or representative of the Company other than its Board of Directors is authorized to change this Contract or waive any of its provisions.

Q. Notification of Change: The Contract Holder will be given notice of any benefit change by a new Group Contract, rider, amendment, or other means as permitted by law. If substantive changes to the Certificate issued thereunder are made, new Certificates or riders or amendments will also be issued.

R. Acceptance of Change: If premium payment is made to the Company after the effective date of any change to the Group Contract, such payment shall be deemed consent to that change.

S. Claims Recoveries

There may be circumstances in which the Company recovers amounts paid as claims expense from the provider of service, from the Insured or from a third party. Such circumstances include rebates paid to the Company by pharmaceutical manufacturers based upon amounts of claims paid by the Company for certain specified pharmaceuticals, amounts recovered by the Company from health care providers or pharmaceutical manufactures through certain legal actions instituted by the Company relating to the claims expense of more than one Insured, recoveries by the Company of overpayments made to health care providers or to Insureds, and recoveries from other parties with whom the Company contracts or otherwise relies upon for payment or pricing of claims. The following rules govern the Company's actions with respect to such recoveries:

1. In the event such recoveries relate to claims paid more than a year and 90 days before the recovery, no adjustment will be made to any Deductible or Coinsurance paid by an Insured and the Company shall be entitled to retain such recoveries for its own use. If the recovery relates to a claim paid within a year and 90 days and is not otherwise addressed herein, Deductible and Coinsurance amounts for an Insured will be adjusted for the applicable benefit period if affected by the recovery.
2. Such recoveries (except for recoveries made within a year and 90 days of the date of the error by the Company of overpayments to health care providers or to Insureds by the Company not involving assertion of a mass claim by the Company) will not be applied for the purpose of group rating or divisible surplus calculation, if applicable, in any event. The cost actually paid by the Company to procure such recoveries will be treated as an administrative expense in considering group rating or divisible surplus, if applicable. The amounts of recovery available in any event to be applied to the group claims expense will be reduced by the cost to the Company to procure that recovery, including amounts paid in attorney fees, amounts paid to collection agencies or other entities, where such entities obtain recoveries on a contingency basis.
3. In the event Blue Cross and Blue Shield of Kansas receives from pharmaceutical manufacturers rebates based upon amounts of claims paid by Blue Cross and Blue Shield of Kansas for certain specified pharmaceuticals, Blue Cross and Blue Shield of Kansas shall be entitled to retain such rebates for its own use, and no adjustments will be made to claims paid on behalf of the Contract Holder, to Deductible, Coinsurance or Copayments/Copays paid by Insureds, or to other cost-sharing or claims amounts.
4. If an Insured is no longer covered by the Company at the time any such recovery is made, regardless of the amount or of the time of such recovery, the Company shall be entitled to retain such recovery for its own use.
5. If such recovery amounts cannot be attributed on an individual basis, because of having been paid as a lump sum settlement for less than the total amount of claims expense of the Company or otherwise, no adjustments will be made to any Deductible, Coinsurance or Copayment/Copay amounts paid by the Insured and the Company shall be entitled to retain such recovery for its own use.
6. The amount of any recoveries which are otherwise available for adjustments to Deductible, Coinsurance or Copayments/Copays will be reduced by the cost to the Company to procure that recovery, including amounts paid in attorney fees, amounts paid to collection agencies or other entities obtaining recoveries on a contingency basis.
7. Under no circumstances shall such claim recoveries include subrogation.

T. For additional information regarding the benefits covered hereunder or to obtain a copy of the list of Contracting Providers that when used will assure that You are receiving the highest possible level of benefits available under Your Certificate, call the Customer Service phone number on Your Identification Card. Information You request about benefits and lists of Contracting Providers will be furnished without charge.

U. **Certificate of Creditable Coverage:** You have the right to request and obtain a Certificate of Creditable Coverage from the Company while You are an Insured and up to 24 months following the date on which Your coverage cancelled. To request a Certificate of Creditable Coverage contact the Customer Service phone number on Your Identification Card.

V. **Contract Holder's Responsibilities Concerning Enrollment:** It is the responsibility of the Contract Holder/employer group's Plan Administrator to submit to the Company for enrollment only those employees and dependents who meet the eligibility criteria of the Contract Holder and the Company, and to ensure and verify the continued eligibility status of covered employees and dependents. The Company has the right to recover from Insureds and/or providers any benefit payments paid on behalf of ineligible persons.

W. **Contract Holder's Responsibilities Concerning Federal Minimum Loss Ratio Rebates**

In the event the Company is required to provide rebates pursuant to 45 CFR 158.240 et.seq., the Contract Holder (and its member employers in the case of an association or multiple employer trust) shall be responsible for calculating the amount of each Certificate Holder's proportionate share and distributing such rebates to

Certificate Holders. Contract Holder (including on behalf of any member employers as noted above) also agrees to timely provide Company with rebate verification data required under 45 CFR 158.242 in the manner requested by the Company.

X. Choice of Law: The terms of this Certificate shall be construed solely pursuant to the laws of the state of Kansas to the extent not pre-empted by federal law.

Form GI-792 1/15

COORDINATION OF THIS GROUP CERTIFICATE'S BENEFITS WITH OTHER BENEFITS

This coordination of benefits (COB) provision applies when an Insured has health care coverage under more than one Plan. "Plan" is defined below.

The order of benefit determination rules below determines which Plan will pay as the Primary Plan. The Primary Plan that pays first pays without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all group Plans do not exceed 100% of the total allowable expense.

A. DEFINITIONS

1. A "Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate Certificates are used to provide coordinated coverage for Insureds of a group, the separate Certificates are considered parts of the same Plan and there is no COB among those separate Certificates.

   a. "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care; school accident-type coverages and governmental benefits, as permitted by law.

   b. "Plan" does not include: individual insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of $200 or less per day; group or group-type accident only coverage, benefits for non-medical components of group long-term care policies; Medicare; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law and the medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts.

   Each Certificate for coverage under a. or b. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

2. The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when compared to another Plan covering the Insured.

   When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

3. "Allowable Expense" means a health care service or expense, including deductible, coinsurance and copayment amounts, that is covered at least in part by any of the Plans covering the Insured. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an Allowable Expanse. The following are examples of expenses or services that are not Allowable Expenses.

   a. If an Insured is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the Insured's stay in a private hospital room is Medically Necessary, or one of the Plans routinely provides coverage for hospital private rooms) is not an Allowable Expense.

   b. If an Insured is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

   c. If an Insured is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, or if one Plan calculates its benefits or services on the basis of usual and customary fees and another Plan provides its benefits or services on the basis of negotiated fees, any amount in excess of the highest of the fees is not an Allowable Expense.

   d. The amount a benefit is reduced by the Primary Plan because an Insured does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

4. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which an Insured has no coverage under this Plan, or before the date this COB provision or a similar provision takes effect.

5. "Closed Panel Plan" is a Plan that provides health benefits to Insureds primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

B. ORDER OF BENEFIT DETERMINATION RULES

When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

1. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.
2. A Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
3. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
4. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

   a. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Plan is primary.

   b. Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one Plan is:

      (1) The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

      (2) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods or plan years commencing after the Plan is given notice of the court decree.

      (3) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

      - The Plan of the custodial parent;
      - The Plan of the spouse of the custodial parent;
      - The Plan of the noncustodial parent; and then
      - The Plan of the spouse of the noncustodial parent.

   c. Active or Inactive Employee. The Plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an 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 is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled B.4.a.

   d. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. 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 is ignored.

e. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is primary.

f. If the preceding rules do not determine the Primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this regulation. In addition, this Plan will not pay more than it would have paid had it been primary.

C. EFFECT ON THE BENEFITS OF THIS PLAN

1. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than 100% of total allowable expenses. The difference between the benefit payments that this Plan would have paid had it been the Primary Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this Plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this Plan will:

   a. Determine its obligation to pay or provide benefits under its contract;

   b. Determine whether a benefit reserve has been recorded for the Insured; and

   c. Determine whether there are any unpaid allowable expenses during that claims determination period.

   If there is a benefit reserve, the Secondary Plan will use the Insured's benefit reserve to pay up to 100% of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

2. If an Insured is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

D. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Company any facts it needs to apply those rules and determine benefits payable.

E. FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

F. RIGHT OF RECOVERY

If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

CANCELLATION

A. Cancellation of the Group Contract: The Group Contract can be canceled effective the date to which premiums have been paid, for several reasons.

Cancellation by the Company:

1. The Company may cancel the Group Contract for the following reasons:
   a. Nonpayment of premiums by the Contract Holder. The Contract Holder has a grace period of 10 days following the due date for payment of premiums. Unless premiums are received by the end of the stated grace period, coverage under this Certificate terminates as of the payment-due date.
   b. Fraud or intentional misrepresentation of a material fact by the Contract Holder, or employer.
   c. Non-compliance with provisions of this Contract.
   d. Failure to meet or maintain the participation or employer contribution requirements of the Company.
   e. The Company ceases to offer a particular type of group coverage provided the provisions of Kansas law associated with such action are met, (including but not limited to obligations to provide at least 90 days prior notice to contract holders and employers of the decision to cease to offer such coverage and the option such terminated groups have to purchase any other group coverage otherwise available from the insurer to a similarly situated group).
   f. If this Contract is issued to a small employer as defined by Kansas or federal law applicable to health insurance, the Company ceases doing business in the small employer market, provided that the provisions of Kansas law associated with such action are met, (including the obligation to provide notices at least 180 days prior to the date of the discontinuation of such coverage, to regulatory authorities, contract holders, and employers of the decision to cease to do such business, all group policies are discontinued and not renewed and the Company does not re-enter the small employer marketplace for five years from the date of notice).
   g. When there is no longer any eligible employee, member or dependent enrolled under this Contract who lives, resides or works in the Company Service Area.

   Cancellation for the foregoing reasons will be effective on the date specified by the Company in a written notice of termination.

Cancellation by the Contract Holder:

The Contract Holder may cancel the Group Contract by giving the Company 15 days advance written notice. Cancellation is effective the date to which premiums have been paid.

B. Termination of an Individual Insured's Coverage under the Group Contract: The coverage of an individual Insured will terminate in the following situations:

1. When the Company is notified that an Insured's coverage is to be removed from the group, the Insured's coverage under this Certificate will end as of the date the Insured's premiums are paid to. The Insured is not entitled to a grace period or benefits during a grace period.
2. Termination of marriage. The coverage of the husband or wife of the person named on the Identification Card ends on the last day of the month in which the divorce was granted by court action.
3. Children who no longer qualify under the general definition of "Insured".
4. Children who are age 18 or over and qualify under the general definition of "Insured" but for whom a written request to terminate coverage has been received.
5. If an Insured permits the use of their or any other Insured's Blue Cross and Blue Shield of Kansas Identification Card by any other person, or uses another Insured's card, all rights of the Insured(s) may be terminated effective immediately upon written notice.
6. If an Insured fails to disclose information requested by Blue Cross and Blue Shield of Kansas or intentionally misrepresents information provided to Blue Cross and Blue Shield of Kansas, then the rights of such Insured under this Certificate may be rescinded with a 30 days minimum written notice. At the effective date of such termination, prepayments received on account of such terminated Insured applicable to periods after the effective date of termination shall be refunded less nonrecoverable claims paid and the Company shall have no further liability or responsibility under this Certificate.
7. When an Insured is determined to be ineligible for coverage provided by this Contract Holder. All rights of the Insured may be terminated effective immediately upon written notice and coverage may be retroactively cancelled effective the first day of the month following the date on which the Insured became ineligible for coverage. At the effective date of such termination, prepayments received on account of such terminated Insured applicable to periods after the effective date of termination shall be refunded and the Company shall have no further liability or responsibility under this Certificate.

C. Reinstatement: If an Insured's coverage is canceled for non-payment of premiums by the Contract Holder (see A.1.a. above), the Company has the right to decide whether or not to reinstate the Group Contract. If coverage is reinstated, there will be no gap in coverage.

D. Benefits When Your Coverage is Canceled: Your coverage ends on the date of cancellation, except for an Insured who is receiving Inpatient Hospital services when that person's coverage terminates. In such case, benefits may be extended for that Insured without payment of premium for a period not less than 31 days following the termination date of the coverage. This extension of benefits shall be secondary to any subsequent replacement group health benefit plan or policy which is intended to provide continuous coverage.

This extension of benefits will be terminated upon the earlier of:

1. the completion of a 31 day period following termination of coverage; or
2. the date Hospital confinement ends.

E. When a grace period for payment of premiums is applicable, benefits are provided during the grace period only if premiums are received by the end of the stated grace period. The only Insureds who have a grace period are those canceled with the whole group under the nonpayment of premiums provision in subsection A.1.a. above.

Form CA-575 1/14

CONTINUED COVERAGE RIGHTS UNDER COBRA AND USERRA, CONTINUED COVERAGE UNDER KANSAS LAW AND CONVERSION

A. COBRA Continuation Coverage - Federal Law

This law applies to employers whose payroll included 20 or more employees during the previous calendar year and such employer's group health plans, not to insurance contractors or third party administrators. That is, if Your employer changes from Blue Cross and Blue Shield of Kansas to another insurance carrier or third party administrator (in the case of a self-funded arrangement), the right to continuation under federal law remains with the employer through the new carrier or to claims adjudication under the new administrator.

CONTINUOUS COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. If You have recently become covered under the group health plan of the Group Contract Holder (the Plan) or have changed to a type of coverage that includes coverage for Your spouse and/or dependent child(ren), this is the initial notice of COBRA continuation coverage rights. Otherwise, this section is included as part of this Certificate for informational purposes. This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to You when You would otherwise lose Your group health coverage. It can become available to You and to other members of Your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about Your rights and obligations under the Plan and under federal law, You should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

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 notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary" You, Your spouse, and Your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You are an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from Your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child".

If the group health plan offered by Your employer includes coverage for retired employees, 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 entity identified on the face page of this Certificate, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after Your employer's Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, for group health plans that include coverage for retired employees commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify Your employer's Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), You must notify Your employer's Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to Your employer's Plan Administrator.

How is COBRA Coverage Provided?

Once Your employer's 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 employees 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), Your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuous coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled and You notify Your employer's Plan Administrator in a timely fashion, You and Your entire family 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 continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If Your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website)

Keep Your Plan Informed of Address Changes

In order to protect Your family's rights, You should keep Your employer's Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to Your employer's Plan Administrator.

Plan Contact Information

USD 262 VALLEY CENTER
143 S Meridian Ave.
Valley Center, KS

The Company has agreed with the employer to undertake only limited duties with respect to COBRA as set forth below.

1. **Payment of Premiums**

   Upon receipt of the COBRA Declaration Form, the Company will send the employee or dependent who qualifies for COBRA continuation of benefits a notice of the amount of premiums needed for the continued benefits. A period of 45 days (from the date of election/declaration) is allowed in which to pay the initial required premiums. The first premium payment will be for a period commencing with the date following the date coverage would otherwise terminate. No gap in coverage will be permitted. The premiums may be higher than for active employees, as permitted by law.

   Subsequent premium payments will be allowed a 30-day grace period after the due date. The Company will bill the Insured directly and payment will be made directly to the Company.

2. **Enrollment and Benefit Changes**

   a. If the group changes benefits, the COBRA Insured's benefits will also change to match the group's new benefit package.

   b. The COBRA Insured has the same right to change benefit programs as the active group employees. If the active employee is allowed to change from HMO coverage to a traditional coverage during the employer's Open Enrollment period, a COBRA Insured is allowed the same opportunity. Transfers which will impose a pre-existing waiting period will not be permitted.

   c. If the employer changes insurers during the period of Continued Group Benefits, the COBRA Insured for that group will be canceled as to coverage under this Certificate and become the responsibility of the new insurer.

   d. The Company shall not be obligated to provide COBRA coverage to You if the Contract Holder or Plan Administrator fails to timely notify You of Your rights under COBRA or You fail to timely elect COBRA coverage.

3. **Conversion Privilege**

   COBRA Insureds who complete the COBRA Continuance of Benefits period are then eligible for a conversion contract offered by Blue Cross and Blue Shield of Kansas at the conversion contract rates then in effect. This conversion is only applicable to Insureds whose group offers health insurance with Blue Cross and Blue Shield of Kansas at the time the Insured's eligibility under COBRA ends. Section D describes the conversion privilege in more detail.

B. USERRA Continuation Coverage - Federal Law

USERRA applies to ALL employer groups even if COBRA does not apply to the employer.

The right to USERRA continuation coverage was created by a federal law, the Uniformed Services Employment and Re-employment Rights Act of 1994 and amendments (USERRA).

Continuation and Reinstatement of Coverage on Account of Qualified Uniformed Service. Apart from the rights to continued coverage described in the preceding information, if applicable, You may be entitled to continue certain aspects of Your coverage (on a self-pay basis) during a period of Qualified Uniformed Service. You also may have certain reinstatement rights following a period of Qualified Uniformed Service. The specific rules are as follows:

1. **Persons Eligible for Continued Coverage.** An employee who is absent from the employment of his or her employer on account of a period of Qualified Uniformed Service may continue employee and dependent medical coverage on a self-pay basis for the 24 month period beginning on the date on which the employee is first absent from employment by reason of Qualified Uniformed Service. Coverage will terminate on the day after the date on which the employee fails to apply for or return to a position of employment, if the failure to apply or return terminates the employee's right to reemployment rights under applicable federal law regarding uniformed service.

2. **Cost of Continued Coverage**. The monthly charge for continued coverage will be determined by the Company, and will be the same for all similarly situated individuals electing the same type of coverage under this provision. If any single period of Qualified Uniformed Service is for a period of less than 31 days, the only amount required to be paid by the employee is the amount, if any, the employee would pay

if he or she had not entered Qualified Uniformed Service. In other cases, the employee's charge will reflect both the employee's portion and the employer's portion, determined in the same manner as COBRA charges.

3. **Benefits Subject to Continuation.** Any election made by an employee applies to the employee and the employee's dependents who otherwise would lose coverage under this Certificate. No separate election may be made by any dependent. The medical coverage that employees are allowed to continue on behalf of themselves and their dependents will be the same as that provided to employees and their dependents under the Plan. Except in connection with circumstances that permit other employees to make changes, an employee may continue only the type of coverage that he or she was receiving on the day before the employee first was absent from employment.
4. **Election of Continued Coverage**. An employee eligible to continue coverage under this provision will be sent an application for continued coverage within 30 days after the Company receives notice, satisfactory to the Company, that the employee will be, or is, absent from employment for a period of Qualified Uniformed Service. If an employee wishes to have coverage continued, he or she must complete the application and return it to the Company within 60 days from the later of the date the application is sent or the date coverage otherwise would terminate.
5. **Payment for Continued Coverage.** The continuation of coverage is conditioned on an employee's payment of the monthly charges for the coverage, determined from the date coverage otherwise would terminate, even if the employee waits 60 days from that date to return the application. If an employee elects continued coverage, payment must be made, relating back to the date that coverage otherwise would terminate, within 45 days after the date the employee elects to continue coverage. After that, payments must be made by the first day of each month for which coverage is to be provided, subject to a 30-day grace period.
6. **Interaction with COBRA** (if applicable):

   Generally, rights to USERRA and COBRA continuation coverage run concurrently from the commencement of Qualified Uniformed Service. Accordingly, employees and/or their dependents may have continuation rights that extend beyond 24 months.
7. **Reemployment Rights**

   If Your coverage has been terminated as a result of the service member's failure to elect continuation coverage, or the service member's length of service, at the time of the service member's reemployment no exclusions or waiting period may be imposed where one would not have been imposed if the coverage of the service member had not been terminated as a result of service in the uniformed services. This provision does not apply to any condition (illness or injury) determined by the Secretary of Veterans Affairs to have been incurred or aggravated during service, however, the service member and any dependents must be reinstated as to all other medical conditions covered by this Certificate.

C. Kansas State Continuation Law

The following provisions of Kansas laws governing group health insurance benefits for hospital, surgical and medical services apply to persons who do not have a right to continue coverage under the federal law.

An employee or such person's covered dependents, whose hospital, surgical or major medical expense insurance (and dental insurance in conjunction with the aforementioned) under the Group Contract has been terminated for reasons such as discontinuance of the Group Contract in its entirety or with respect to an insured class of persons, is entitled to have such continuation coverage under the Group Contract, subject to the following provisions:

1. The employee or covered dependent must have been continuously insured under the Group Contract (or a group policy providing similar benefits which was replaced by the Group Contract) for at least three (3) months immediately prior to termination.
2. Such group benefits may be continued under the Group Contract for a period of 18 months.

   Clarification:

   A dependent whose eligibility as a dependent ceases during the 18-month period may complete the 18-month period under separate coverage.
3. Continuation of group benefits does not apply:
   a. Where persons are on continuation coverage and during that 18-month period the Group Contract is replaced. Such persons for that group will be canceled as to coverage under this Contract and become the responsibility of the new insurer.
   b. When termination of coverage under the Group Contract occurs because any employee failed to pay any required contribution.
   c. When the employee is or could be covered by Medicare.

d. When the employee is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination.

e. When coverage for an Insured is terminated pursuant to items B. 5, 6 or 7 of the Cancellation Section.

4. Notice of Right to Continue Group Benefits: The Insured named on the Identification Card will be notified of their right to continue their group benefits. The Insured must provide written notification that they wish to continue their group coverage to the Company within 60 days of the date an event occurs which would qualify an Insured for continuation coverage under this provision. Upon receipt of the written notification from the Insured, the Company will send the employee or dependent who qualifies for continuation of group benefits a notice of the amount of premiums needed for the continuation benefits. A period of 45 days from the date the Insured elects to continue group benefits is allowed in which to pay the initial required premiums. The first premium payment will be for a period commencing with the date following the date coverage would otherwise terminate. No gap in coverage will be permitted.

   Subsequent premium payments will be allowed a 30-day grace period after the due date. The Company will bill the Insured directly and payment will be made directly to the Company.

D. Conversion Privilege

1. A conversion privilege is available to the following persons:

   a. Those who have completed the period of Continued Group Benefits provided for in Section A, B, or C above if Blue Cross and Blue Shield of Kansas is the insurer or administrator of that employer group health plan at the termination of such benefits.

   b. Those who during the period of Continued Group Benefits provided for in Section A, B, or C above choose to change to the Conversion Contract and so notify the Company. (So doing forever forfeits any right to further Continued Group Benefits.)

   c. Those who at the time of initial eligibility for Continued Group Benefits under Section A or B above choose to go directly at that time to the Conversion Contract. (So doing forever forfeits any right to Continued Group Benefits.)

   d. Those who do not qualify for Continued Group Benefits under either Section A or B above.

2. A conversion privilege is not applicable to Insureds who have their coverage terminated pursuant to items B.5, 6, or 7 of the Cancellation Section or to the following persons if the benefits referred to in paragraph b. below for such person or benefits provided or available under the sources referred to in paragraphs c. and d. below for such person, together with the benefits provided by the converted policy, would result in over-insurance based on Company standards as filed with the Kansas Insurance Department:

   a. Those who are or could be covered by Medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded).

   b. Those who are covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program, or

   c. Those who are eligible for similar benefits (whether or not covered therefore) under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, or

   d. Those who have or have available similar benefits pursuant to or in accordance with the requirements of any state or federal law.

3. Conversion Notice

   The Company will mail a conversion notice to those persons specified in Section D.1. Within 31 days of receipt of the notice, the person has the right to apply for coverage by remitting the required premiums. The first required premium payment will be for a period commencing with the day following the date coverage would otherwise terminate. No gap in coverage will be permitted.

   Persons who are enrolled in Continued Group Benefits will be mailed the conversion notice prior to the end of the period for continued group benefits.

   a. Notice to the Insured named on the Identification Card: The notice will be mailed to the Insured's latest address as it appears on the records of the Company.

   b. Notice to dependents who cease to be eligible: The notice will be mailed to the dependent at the address provided the Company when the Company is notified that such person is no longer an eligible dependent.

4. The contract does not require evidence of insurability of the person to be covered.

BLUE CHOICE RIDER

PART 1. GENERAL

This is a Rider to Your Certificate. It becomes effective on the date shown in the records of Blue Cross and Blue Shield of Kansas.

The conditions described in Your Certificate also control this Rider except where this Rider specifically states there is a change.

PART 2. ENROLLMENT IN BLUE CHOICE

The Contract Holder and Insured agree to the following related to the offering of Blue Choice and the Insured's enrollment therein:

A. Blue Choice Providers

"Blue Choice Provider" means an Institutional Provider or Professional Provider of health care services that has entered into an agreement with the Company under which it is classified as a Blue Choice Provider.

"Blue Plan Preferred Provider" means an Eligible Provider that has entered into an agreement with a Blue Cross and/or Blue Shield Company (other than Blue Cross and Blue Shield of Kansas) under which additional deductibles and/or coinsurances for use of a non-preferred provider do not apply to such Eligible Provider.

The Company will provide the Contract Holder with listings of the Blue Choice Providers in the Company Service Area. You may call the number listed on the Insured's Identification Card if You wish to determine if a provider outside the Company Service Area is a Blue Plan Preferred Provider.

B. Use Blue Choice Providers or Blue Plan Preferred Providers

To receive the maximum level of benefits from Your Blue Choice coverage, You must use Blue Choice or Blue Plan Preferred Providers. Section C describes the lesser benefits when non-Blue Choice Providers or non-Blue Plan Preferred Providers are used.

C. Additional Coinsurance

You will be responsible for an additional 20% of the Allowable Charge up to a maximum additional coinsurance of $2,000 per Insured per Benefit Period or $4,000 for all Insureds on family coverage per Benefit Period that would otherwise be allowable if You fail to use a Blue Choice Provider or a Blue Plan Preferred Provider. This additional coinsurance does not accumulate toward the satisfaction of any other deductible, coinsurance or shared payment called for by Your Certificate, and those other deductibles, coinsurances or shared payment amounts called for by Your Certificate continue to apply.

The additional coinsurance is not applied when service is required for a Medical Emergency or a life, limb, or function-threatening Accidental Injury.

The Company has no obligation to advise You of the applicability of additional coinsurances for use of a non-Blue Choice Provider or a non-Blue Plan Preferred Provider during the course of pre-authorization or otherwise. You are responsible for choosing their providers of health care services.

Form RI-438 1/14

SUPPLEMENTAL ENDORSEMENT ISSUED BY BLUE CROSS AND BLUE SHIELD OF KANSAS, INC.

As a Blue Cross and Blue Shield of Kansas Insured You have the opportunity to take advantage of savings programs that are collectively called Resource Blue which are being offered at no additional cost to You. These programs are not insurance but instead discount programs that will help You with specified expenses for services that are not eligible for coverage under Your Blue Cross Blue Shield of Kansas coverage.

The types of services included are:

- Vision Care
- Hearing Care
- Complementary and Alternative Medicine

Disclaimer

The above savings programs are made possible through arrangements with various providers and vendors. Changes in these arrangements and/or their discontinuance may occur in the future at the discretion of Blue Cross and Blue Shield of Kansas.

Form 80-2113 7/05

GROUP: 09327

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ISSUED TO: SAMPLE 09/11/2015
GROUP ID: 09327 INSURED ID: SAMPLE

Women's Health Care and Cancer Rights Act (WHCRA) Notice

In accordance with the requirements of WHCRA and K.S.A. 40-2, 166 Blue Cross and Blue Shield of Kansas is notifying you of the following coverage mandated by state and federal law. When the need for such benefits is determined by the Insured and the Insured's attending physician, benefits include the following:

- Reconstruction of the breast on which a mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatments for physical complications of all stages of mastectomy, including lymphedemas.

Normal deductible, coinsurance, and/or copay amounts applicable to your health coverage are also applicable to these benefits.

BlueCross BlueShield of Kansas

An Independent Licensee of the
Blue Cross Blue Shield Association.

GROUP NAME: USD 262 VALLEY CENTER

GROUP NUMBER: 09327

ISSUED TO: SAMPLE

IDENTIFICATION NUMBER: SAMPLE

Form FL-793 1/14

ISSUED TO: SAMPLE 09/11/2015
GROUP ID: 09327 INSURED ID: SAMPLE

10/01/2015

ISSUED TO: SAMPLE 09/11/2015
GROUP ID: 09327 INSURED ID: SAMPLE

An Independent Licensee of the
Blue Cross Blue Shield Association.

The following information is either provided to you as an insured, or is available to you upon request:

- A complete description of the health care services, items and other benefits to which you are entitled.
- A complete description of limitations, exceptions and exclusions of your health benefit plan.
  - A listing of contracting providers, their business addresses, telephone numbers, availability and any network limitations.
  - A notification in advance of any changes in the health benefit plan which either reduces coverage or benefits, or increases the cost of the plan.
  - A description of the appeal procedures available under the health benefit plan and your rights regarding termination, disenrollment, nonrenewal or cancellation of coverage.

GROUP NAME: USD 262 VALLEY CENTER

GROUP NUMBER: 09327

ISSUED TO: SAMPLE

IDENTIFICATION NUMBER: SAMPLE

Form FL-794 1/14

10/01/2015

ISSUED TO: SAMPLE 09/11/2015
GROUP ID: 09327 INSURED ID: SAMPLE

10/01/2015

ISSUED TO: SAMPLE 09/11/2015
GROUP ID: 09327 INSURED ID: SAMPLE

Privacy of financial information is of concern to all of us, and in response to these concerns, the federal government has required states to adopt laws that require insurance companies to explain their privacy practices. This federal law is commonly referred to as Gramm-Leach-Bliley and is separate from the federal law commonly referred to as HIPAA Privacy which became effective on 4/14/2003 and for which You have been sent the Notice of Privacy Practices concerning protected health information as required by that law. Our privacy practices for "non-public personal financial information" are set out below. We want to assure You that we take Your privacy concerns seriously, and join with Your lawmakers in believing this disclosure of such practices is an important idea.

OUR PRIVACY PRACTICES REGARDING FINANCIAL INFORMATION

Blue Cross and Blue Shield of Kansas has the following practices regarding nonpublic personally identifiable financial information with respect to our customers.

The nonpublic personal financial information we collect consists of information You provide in applications or enrollment forms (such as name, address, social security number, telephone number), or changes in that information You submit to us, and whether You hold other health coverage.

We collect such information from the following sources:

- Information we receive from You on applications or other forms;
- Information about Your transactions with us and our affiliate;
- Information we receive from others, if You hold duplicate coverage subject to coordination with coverages we issue or administer.

We do not disclose such information about our customers or former customers to anyone except:

- We disclose such information as permitted by law. Examples of disclosures we make which are permitted by law include disclosures of the fact of enrollment (a type of personally identifiable financial information) collected by one affiliate to the other, disclosures to persons providing services to us necessary to adjudicate claims, and disclosures to health care providers allowing such providers to determine your eligibility for coverage.
- We may disclose Your name, address and telephone number which we receive from You on Your applications or other forms to companies that perform customer satisfaction or other surveys on our behalf. Such companies have agreed not to redisclose such information to others.

We restrict access to nonpublic personal financial information about You to those employees who need to know that information to provide products or services to You. We maintain physical, electronic, and procedural safeguards to guard Your personal financial information.

ISSUED TO: SAMPLE 09/11/2015
GROUP ID: 09327 INSURED ID: SAMPLE

10/01/2015

An Independent Licensee of the
Blue Cross Blue Shield Association.

COMPREHENSIVE MAJOR MEDICAL GROUP CERTIFICATE

This Certificate describes the benefits provided in a Group Contract by Blue Cross and Blue Shield of Kansas, Inc. (herein called "Blue Cross and Blue Shield of Kansas" or "the Company") Topeka, Kansas, and the exclusions and limitations. This Certificate may be canceled as described in this Certificate.

To the extent that benefits of this Certificate are part of an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act (commonly known as ERISA), Blue Cross and Blue Shield of Kansas shall have the full and exclusive authority to construe covered benefits that are stated in the Certificate.

GROUP NAME:	USD 262 VALLEY CENTER
GROUP NUMBER:	09327
ISSUED TO:	SAMPLE
IDENTIFICATION NUMBER:	SAMPLE

You have specific consumer rights regarding internal and external appeals. Our complete appeals procedure process is available in Spanish. To request a Spanish version of the appeals process, please call our Customer Service number on the back of your member identification card.

Usted tiene derechos específicos como consumidor con relación a las apelaciones internas y externas. Nuestro proceso completo para el procedimiento de apelaciones está disponible en español. Para solicitar una versión en español del proceso de apelaciones, llame a nuestro número de Servicio al cliente que se encuentra en la parte posterior de su tarjeta de identificación del afiliado.

Form FL-836 1/15

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GENERAL DEFINITIONS

A. **Accidental Injury** is an unintended injury to Your body caused through external means. "Accidental Injury" does not include: injuries that occur before the date from which You have had continuous coverage with the Company; disease or infection (except for infection that occurred from an accidental cut or wound); hernia; injuries to the teeth caused by biting or chewing.

B. **Alternate Recipient** means any child of an Insured who is recognized under a Qualified Medical Child Support Order as having a right to enrollment under this Contract.

C. **Blue Cross Company and/or Blue Shield Company** means the Company and any other corporation approved or licensed by the Blue Cross Blue Shield Association to use the registered service marks and names.

D. **Certificate** means a summary of the provisions of the Group Contract that affect Insureds. A Certificate is issued by the Company to the Contract Holder for delivery to each enrolling employee.

E. **Coinsurance** means the percentage of the allowable charge for a covered service at which payment is made after any applicable Deductible amount has been satisfied.

F. **Company** means Blue Cross and Blue Shield of Kansas.

G. **Company Service Area** means the State of Kansas except Johnson and Wyandotte Counties.

H. **Contract or Group Contract** means the Contract between the Company and the Contract Holder and includes: all of the forms issued to the Contract Holder by Blue Cross and Blue Shield of Kansas, including endorsements, amendments, and riders.

I. **Contracting Provider** means an Eligible Provider who has entered into a Contracting Provider Agreement with the Company.

J. **Convalescent Care, Custodial/Maintenance Care or Rest Cures** means treatment or services, regardless of by whom recommended or where provided, in which the service could be rendered safely and reasonably by self, family, or other caregivers who are not Eligible Providers. The purpose of the services are designed mainly to help the patient with daily living activities, to maintain their present physical and mental condition, or provide a structured or safe environment.

K. **Copayment or Copay** means the amount of the allowable charge for a covered service required to be paid by an Insured before benefits can be provided.

L. **Credible Evidence** means scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations or consensus among experts.

M. **Deductible** means the amount of the allowable charges for covered services required to be paid by an Insured before benefits can be provided. Amounts applied toward the Deductible are accumulated until a specified dollar maximum has been reached during a Benefit Period after which no additional Deductible amount is required for the remainder of that Benefit Period.

N. **Eligible Provider** means any of the following providers when services provided are within the scope of the licensure of the provider. NOTE: Providers recognized by Medicare as Independent Diagnostic Testing Facilities (IDTFs) are not considered Eligible Providers unless they meet the applicable criteria as set out in the definitions below.

1. **Ambulance Service** means any form of transportation specially designed, equipped, and intended to be used for the purpose of transporting ill or injured persons and is operated according to state and local laws which control the issuing of valid licenses or permits for the operation of an Ambulance Service.

2. **Ambulatory Surgical Center** means a facility that meets all of the following criteria: (1) is licensed by the proper licensing agency as an ambulatory surgical center; (2) is not a part of a Hospital; (3) provides hospital-type services for Outpatient surgery.

3. **Professional Provider** means any of the following health practitioners licensed or certified to provide health services in the state of Kansas:

   - Advanced Registered Nurse Practitioner (ARNP)/Advanced Practice Registered Nurse (APRN);
   - Any of the following when authorized to engage in private, independent practice under the laws of the state in which covered services are received:
     - Licensed Clinical Marriage and Family Therapist (LCMFT);
     - Licensed Clinical Professional Counselor (LCPC);
     - Licensed Clinical Psychotherapist (LCP);
     - Licensed Specialist Clinical Social Worker (LSCSW);
   - Audiologist;
   - Autism Specialist or Intensive Individual Service Provider as defined by the Kansas Department for Aging and Disability Services;

- Certified Diabetic Educator/Licensed Dietitian (for covered diabetic education services);
- Doctor of Chiropractic (DC);
- Doctor of Dental Surgery (DDS);
- Doctor of Medicine (MD);
- Doctor of Osteopathy (DO);
- Licensed Physical Therapist (LPT);
- Occupational Therapist;
- Doctor of Optometry (OD);
- Oral Surgeon;
- Physician Assistant (PA);
- Doctor of Podiatric Medicine (DPM);
- Psychologist licensed to practice under the laws of the state in which covered services are received; and
- Speech-Language Pathologist.
- Licensed Mental Health Technician (LMHT)
- Licensed Practical Nurse (LPN)
- Registered Nurse (RN)
- Respiratory Therapist (LRT)
- Athletic Trainer (AT)
- Naturopathic Doctor (LND)
- Licensed Radiological Technologist (LRTC)
- Master Level Psychologist (LMLP)
- Addiction Counselor (LAC)
- Licensed Master/Bachelor Social Worker (LMSW/LBSW)
- Dental Hygienist (LDH)
- Dietician (LD)

4. **Free-Standing Birthing Center** means a facility, operated by a licensed physician, that performs uncomplicated normal/routine (i.e., non-Cesarean) deliveries of newborns.
5. **Free-Standing Cardiac Catheterization Laboratory** means:

   - A facility approved by Medicare to perform diagnostic cardiac catheterization procedures
   - Performs only diagnostic cardiac catheterization procedures
   - Does so in a non-Hospital outpatient setting

6. **Free-Standing Dialysis Center** means a facility approved by Medicare to perform dialysis and related services.
7. **Free-Standing Imaging Center** means a facility operated by a licensed physician and approved by Medicare to perform specialized diagnostic and radiologic tests.
8. **Free-Standing Sleep Center/Laboratory** mean a facility that only performs sleep studies.
9. **Home Health Agency** means:

   - A public agency or private organization which is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's place of residence.
   - Has policies established by a group of professional personnel which governs the skilled nursing and therapeutic services which it provides
   - Maintains clinical records on all patients
   - Is licensed according to state and local laws
   - Is certified by Medicare

10. **Hospital** means any of the following types of institutions:

    - The acute care, psychiatric, rehabilitation and long-term acute care sections of a licensed general hospital
    - Other facilities licensed by their state of operation as a hospital that provide acute care services
    - Licensed privately operated psychiatric hospitals
    - Health care institutions operated by the State of Kansas or the United States government

    Hospital does **not** include any of the following, even if licensed as a hospital:

    - Ambulatory Surgical Centers
    - Clinics
    - Doctors' offices
    - Facilities that are primarily for the care of convalescents
    - Health resorts
    - Nursing homes
    - Private homes
    - Residential or transitional living centers
    - Residential treatment centers or similar facilities
    - Rest homes
    - Skilled nursing facilities

11. **Independent Laboratory** means a medical laboratory that is CLIA-certified Medicare to perform diagnostic and/or clinical tests and is independent of an Institutional Provider or a Professional Provider's office.
12. **Institutional Provider** means a Hospital, Medical Care Facility, or Ambulatory Surgical Center.
13. **Medical Care Facility** means a facility that is not a Hospital (see definition) but that is: an alcoholic treatment facility; a drug abuse treatment facility; or a community mental health center. To qualify as a Medical Care Facility, the facility must also be licensed by the State of Kansas to provide diagnosis and/or treatment of a Mental Illness or Substance Use Disorder.
14. **Other Eligible Providers** (as limited herein)
    a. Adjunct Providers means only the following providers that perform Covered Services under the direction of a Professional Provider.
        1. Certified Occupational Therapy Assistant
        2. Certified Physical (Therapy) Therapist Assistant
    b. Registered Nurse and Licensed Practical Nurses are Eligible Providers for Home Health Care and Private Duty Nursing only, but may also perform services incidental to and on behalf of services rendered and billed by a Professional Provider. Examples include, but are not limited to injections/immunizations, ECGs, and pulmonary function testing. Certified Registered Nurse Anesthetists (CRNA) are also Eligible Providers for anesthesia services.
    c. Orthopedic/Prosthetic Device Supplier
    d. Home Medical Equipment Supplier
    e. Infusion Therapy Providers licensed to provide infusion therapy in the state in which services are received, e.g., infusion suites, home infusion therapy providers.
    f. Specialty Pharmacy for dispensing Specialty Prescription Drugs eligible for coverage under the Comprehensive Program.
    g. Hospice means a Medicare Certified organization or agency providing comprehensive, continuous Outpatient and home-like Inpatient care for terminally ill patients and their families and is licensed to practice under the laws of the state in which covered services are received.

O. Eligible Provider for Mental Illness or Substance Use Disorders

- A Hospital;
- A Medical Care Facility;
- A Licensed Doctor of Medicine, or Doctor of Osteopathy;
- A psychologist licensed to practice under the laws of the state in which covered services are received;
- A Licensed Specialist Clinical Social Worker authorized to engage in private, independent practice under the laws of the state in which covered services are received;
- Advanced registered nurse practitioner;
- A Licensed Clinical Marriage and Family Therapist;
- A Licensed Clinical Professional Counselor;
- A Licensed Clinical Psychotherapist.

P. Except as limited is a phrase You will see before explanations of Covered Services. It means that all coverage under this Certificate is controlled by the conditions described in this Certificate, including exclusions.

Q. Experimental or Investigational refers to the status of a drug, device, medical treatment or procedure:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished and the drug or device is not Research-Urgent as defined in these General Definitions except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or
2. if Credible Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not Research-Urgent as defined in these General Definitions except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or
3. if Credible Evidence shows that the consensus among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis and the trials are not Research-Urgent as defined in these General Definitions except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment

of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature; or

4. if there is no Credible Evidence available that would support the use of the drug, device, medical treatment or procedure compared to the standard means of treatment or diagnosis except for prescription drugs used to treat cancer when the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

R. **Identification Card** means a card issued to identify You as an Insured of the Company.

S. **Inpatient** means a setting where services are provided when You have been admitted to a Hospital or Medical Care Facility.

T. **Insured** means the person named on the Identification Card.

Insured also means the following persons that have been duly enrolled in the Company's records according to the specifications set forth in the Enrollment and Effective Dates Section:

1. The husband or wife of the person named on the Identification Card; and
2. Each dependent child by birth, adoption, legal guardianship, or court-ordered custody of the Insured named on the Identification Card or such person's spouse, who is:
   a. Under 26, or
   b. Age 26 or over provided the child is unmarried and covered as a dependent child under a policy or certificate issued by the Company or other creditable coverage (as defined under HIPAA) upon reaching age 26, has no more than a 63-day gap in dependent or handicapped dependent coverage prior to application for coverage hereunder, and is incapable of self-support due to a severe handicap resulting from a physical condition or a Mental Illness or Substance Use Disorder prior to their 26th birthday. For such a child to be an Insured, You must request from and submit to the Company a special application within 63 days of the latter of the following: a) the child's 26th birthday (but no earlier than 60 days prior); or b) the first opportunity for the child to enroll for coverage hereunder or accrual of a special enrollment right pursuant to HIPAA. The Company will then determine the child's eligibility. If the child is eligible, the coverage will be effective according to the specifications set forth in the Enrollment and Effective Dates Section.

      The Company will request written proof from time to time related to this child's incapacity and dependence. This child's coverage will end when the child is no longer disabled or dependent.

Insured does not refer to persons who have been voluntarily disenrolled by the person named on the Identification Card.

U. **Intensive Care Unit** means a specialized room or area or section in a Hospital which includes:

- Beds in a distinctly identifiable unit that are used only for critically ill or injured patients
- A separate nursing staff, with a qualified Registered Nurse in 24-hour attendance while the unit is occupied ("Qualified" means the nurse has had special training in intensive care nursing.)
- Special supplies and equipment needed to care for critically ill or injured patients

V. **Medical Emergency** means a sudden and, at the time, unexpected onset of a health condition that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect to require immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. Medical Emergency does not include the onset of a health condition while an Inpatient.

W. **Medically Necessary** describes a service or supply performed, referred or prescribed by a provider in the most appropriate setting and consistent with the diagnosis and treatment of the patient's condition in accordance with generally accepted standards of medical practice in the United States based on credible scientific evidence and not primarily for the convenience of the patient, physician, or other health care provider.

X. **Medicare** means Title XVIII of the Social Security Act as amended now and in the future, any rules and regulations authorized by any agency authorized to administer that Act.

Y. **Mental Illness or Substance Use Disorder** means a disorder specified in the Diagnostic and Statistical Manual of the American Psychiatric Association IV (1994). This does not include any condition or problem that is designated in the DSM IV (1994) as a focus of clinical attention.

Z. **Non-Contracting Provider** means an Eligible Provider who has not entered into a Contracting Provider Agreement with Blue Cross and Blue Shield of Kansas.

AA. **Open Enrollment** means the period of time during which eligible persons who have not previously enrolled with the Company within the time periods specified, following their first opportunity or an event, as defined by state or federal law, that qualifies them for coverage, may do so. This time period is the 30 days preceding

the anniversary month of the Contract Holder. If agreed upon by the Contract Holder and the Company, different, additional or longer Open Enrollment Periods may be established.

BB. Outpatient means a setting where provided services are other than as an Inpatient in a Hospital or Medical Care Facility. These settings include but are not limited to the Outpatient department of a Hospital, an Ambulatory Surgical Center, a clinic or a Professional Provider's office.

CC. Rehabilitation Services means therapies that, when provided in an Inpatient or Outpatient setting, are designed to restore physical functions following an Accidental Injury or an illness.

DD. Research-Urgent means a drug, device, medical treatment or procedure that is otherwise excluded by this Certificate as Experimental or Investigational (see General Definitions and General Exclusions) but meet all the following criteria:

1. It is therapeutic (not diagnostic or supportive) treatment used to directly improve health outcomes for a condition that is either life threatening or severely and chronically disabling and that has a poor prognosis with the most effective conventional treatment.

   a. For purposes of Research-Urgent Benefits a condition is considered life threatening if it has a substantial probability of causing premature death and all other conventional treatments have failed.

   b. For purposes of Research-Urgent Benefits a condition is considered severely and chronically disabling if the individual with the condition is unable to perform even the functions that are required for daily life and if the severe disability is not expected to improve with the most effective conventional treatment.

2. There is Credible Evidence that the treatment may provide a clinically significant and substantial improvement in net health outcome compared to the most effective conventional treatment, or where conventional treatment has failed or is not medically appropriate.

3. Regardless of funding source, the drug, device, medical treatment or procedure is available to the Insured seeking it and will be provided within a well designed clinical trial conducted by the National Institute of Health, Inc. or by an institution or entity which the protocol for the drug, device, medical treatment or procedure has been approved by an Institutional Review Board that is in compliance with the ethical principles in: (a) The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research or the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, or (b) other appropriate ethical standards recognized by federal departments and agencies that have adopted the Federal Policy for the Protection of Human Subjects.

EE. Sound Natural Tooth means a tooth that is whole or properly restored; is without advanced periodontal disease and is not in need of the treatment provided for any reason other than an Accidental Injury.

FF. Utilization Review means an evaluation of the medical necessity, appropriateness, and efficiency of use of health care services, procedures, and facilities.

The claims review is done by consulting practicing Doctors in cooperation with Your Doctor.

GG. You and Your refer to the Insured.

Form GD-2142 1/15

ENROLLMENT AND EFFECTIVE DATES

A. Initial Establishment of Coverage

The Contract Holder (or employer if different) shall submit to the Company an individual application for each eligible employee electing coverage. These applications will be accepted if received by the Company within 60 days of the person's date of initial eligibility to enroll.

If the Contract Holder offers a choice of two or more optional health benefit programs, an Insured may elect only one of the programs offered.

For those who are enrolling at their initial opportunity, coverage will be effective on the first of the month following the initial opportunity to enroll as long as the application is received by the Company within 60 days of the person's initial opportunity to enroll.

For those who do not make application within the time periods set forth above, but who are enrolling in conjunction with an event, as defined by state or federal law, that qualifies them for coverage, such coverage will be effective on the first of the month following the event that qualifies them for coverage as long as the application is received by the Company within 60 days of the event except when the event is birth, adoption, placement for adoption, or discharge from the military in which case the effective date will be the date of the event.

B. Adding Dependents

The Contract Holder (or employer) shall notify the Company in writing when an Insured's coverage should be changed to either add or drop a dependent or dependents when such a change would result in the establishment of a different coverage type, e.g., employee only coverage to employee/spouse coverage or vice versa. If the notice of change is received by the Company within 60 days of the Insured's marriage date or the date of the event, as defined by state or federal law, which qualifies the dependent for coverage hereunder, such change will be accepted. Changes in coverage type will be the first of the month following the date the dependent became eligible for coverage.

C. Care for Newborns and Mothers

Inpatient services in a Hospital are covered for at least 48 hours following a vaginal delivery and at least 96 hours following delivery by a cesarean section for the newborn child of an Insured and the mother (if an Insured) of such newborn.

The Company has the right to determine the medical necessity of any length of stay beyond the 48-96 hours described above.

In the event that coverage hereunder provides benefits for only the parent(s) of the newborn child, coverage must be changed to a type that provides benefits for dependent children within the time period required for such change (as set forth above) in order for the newborn child's coverage to continue beyond the initial 48 or 96 hour periods described above.

Covered services received by the child prior to coverage being changed to a type that provides benefits for dependent children, will be treated as though they were services received by the parent Insured.

D. Newborn Child/Adopted Child Coverage

Notwithstanding any provision to the contrary, under existing coverage that provides benefits for two or more Insureds, a newborn of the person named on the Identification Card or the spouse of the person named on the Identification Card or a child (regardless of age) adopted by the Insured or placed in the Insured's home by a child placement agency as defined by state law for the purpose of adoption, is covered as follows:

1. In the case of natural newborns, newborns for which the petition for adoption has been filed within 31 days following birth, or newborns placed in the Insured's home within 31 days following birth, coverage will be effective and provided without charge for 31 days beginning on the date of birth.
2. In the case of adoptions subsequent to the first 31 days of birth, coverage will be effective and provided without charge for 31 days beginning on the date the petition for adoption was filed.
3. In the case of placement of a child in the Insured's home by a child placement agency as defined by state law for the purpose of adoption subsequent to the first 31 days of birth, coverage will be effective and provided without charge for 31 days beginning on the date of placement.

Under a coverage type that provides benefits for children, no change in coverage type is required. However, additional premiums may be required.

Under coverage that provides benefits for an employee or employee and spouse only, the coverage must be changed to a coverage type that would include the child in order for the child to have coverage beyond the first 31 days.

E. Dependent coverage pursuant to a Qualified Medical Child Support Order

Coverage will be effective on the first day of the month following the date on which the Company qualifies the order. Medical Child Support Orders must be qualified by the Contract Holder and the Company pursuant to specifications of federal and state law. The procedure for qualification is to timely submit the Medical Child Support Order to the Contract Holder for initial qualification or rejection. The Contract Holder will forward the order to the Company for qualification or rejection with notice to the parties to the order. If the order is qualified, an Identification Card, Certificate and claim form will be issued to the Alternate Recipient.

F. Coverage begins on the date this coverage becomes effective for the Insured as reflected in the records of Blue Cross and Blue Shield of Kansas and determined according to the provisions set forth in this Enrollment and Effective Dates section.

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G. Special Enrollment Rights

Special Enrollment Rights are recognized when an eligible employee, spouse, or dependent involuntarily loses group health plan or health insurance coverage in connection with designated qualifying events as outlined below or becomes eligible for state premium assistance as provided below, or when an eligible employee acquires a spouse and/or dependent(s). Under these circumstances, coverage may be added for certain individuals wishing to become covered hereunder if such individuals are otherwise eligible for coverage and enroll within 60 calendar days of the event creating the Special Enrollment Right.

The effective date of coverage arising from Special Enrollment Rights will be as provided in the applicable provision above in this Enrollment and Effective Dates section.

Special Enrollment Rights are recognized for the following qualifying events only:

1. Involuntary loss of other medical coverage in which:
   -- The other coverage was the basis for You, Your spouse, and/or dependent(s) declining coverage hereunder; AND
   -- The loss of other coverage occurred solely due to one of the following designated qualifying events: loss of eligibility for such coverage or exhaustion of COBRA or state continuation coverage. Note: Special Enrollment Rights are not recognized if coverage and/or eligibility was lost due to any of the following: failure on the part of the employee, spouse, or dependent, as applicable, to pay contributions/premiums on a timely basis, submission of fraudulent claims, or intentional misrepresentation of material information.
2. Complete cessation of employer contributions toward non-continuation group coverage
3. Marriage of employee
4. Birth
5. Adoption or placement for adoption
6. Becoming eligible for a state premium assistance program under Medicaid or a state Children's Health Insurance Program (CHIP).

Who accrues Special Enrollment Rights

The accrual of Special Enrollment Rights varies according to the qualifying events listed above. Special Enrollment Rights are recognized only for individuals as provided below:

1. For loss of other coverage or cessation of employer contributions: the employee, spouse, and any dependents losing such other coverage or employer contribution.
2. For marriage, birth, adoption, or placement for adoption: the employee, spouse, and any newly-acquired dependent(s) only.
3. For state premium assistance eligibility: the employee and any dependents.

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COMPREHENSIVE PROGRAM

A. Benefits

1. **Benefit Period:** The 12 month period beginning on April 1.
2. **Deductible per Benefit Period:** $1,500 for any one Insured, not to exceed $3,000 for all Insureds on family coverage (in aggregate). Charges incurred in the last three months of a Benefit Period that applied to the Deductible of that Benefit Period can also be applied to the Deductible of the next Benefit Period.
3. **Coinsurance:** After the Deductible has been met, the Company will make benefit payments for 80% of the allowable charge. When the amount You have paid in Coinsurance in the Benefit Period reaches $1,000 for any one Insured or $2,000 for all Insureds on family coverage (in aggregate), the amount payable for the rest of the Benefit Period will be 100% of the allowable charge.
4. **Annual Out-of-Pocket Maximum:** $6,350 for any one Insured not to exceed $12,700 for all Insureds on family coverage. No one Insured on family coverage will be required to contribute more than the single Annual Out-of-Pocket Maximum towards the family Annual Out-of-Pocket Maximum. Out-of-Pocket expenses include the Deductible, Coinsurance and Copayment provisions under the Comprehensive Program, Prescription Drug Program and Mail Order Prescription Drug Program. After You have reached the Annual Out-of-Pocket maximum, eligible services will be paid at 100% of the allowable charge for the remainder of the Benefit Period. If You are enrolled in a dental care program, Coinsurance applicable to the dental care program does not apply to this Annual Out-of-Pocket Maximum.
5. **Home or Office Visit Copay:** A Copay of $25 will apply to each home or office visit. Any amounts You pay to satisfy this Copay do not apply toward satisfaction of any other Deductible, Coinsurance, or Copayment/Copay, except amounts in excess of the allowable charge for a Home or Office Visit shall be used toward the satisfaction of Deductible, Coinsurance, or Copayments for other covered services rendered during the same Home or Office Visit. Such amounts shall not be credited towards applicable aggregate amounts for the Benefit Period.
6. **Immunizations and Injections:** Benefits for covered immunizations and injections provided on an Outpatient basis will be paid at 100% of the allowable charge.
7. **Outpatient Laboratory and Radiology Services**

   Services that are not associated with an Accidental Injury:

   Benefits for covered laboratory and radiology services provided on an Outpatient basis will be paid at 100% of the allowable charge up to a maximum payment of $300 per Insured per Benefit Period after which benefits are subject to the Deductible, Coinsurance and/or Copayment/Copay amounts required for other covered services.

   Services that are associated with an Accidental Injury:

   Benefits for covered laboratory and radiology services provided on an Outpatient basis will be paid at 100% of the allowable charge until the Enhanced Accidental Injury Benefit (see #9 below) has been exhausted. After the Enhanced Accidental Injury Benefit has been exhausted, all remaining allowable charges for covered laboratory and radiology services are subject to the Deductible, Coinsurance and/or Copayment/Copay amounts required for other covered services.
8. **Emergency Room Copayment:** A Copayment of $100 will apply to each Hospital emergency room visit (Applies only to Institutional Provider services, not to services of Professional Providers.) This Emergency Room Copayment is in addition to any other Deductible, Coinsurance or Copayment/Copay amounts. For services associated with an Accidental Injury, this Copayment shall not apply until the Enhanced Accidental Injury Benefit (see #9 below) has been exhausted. This Emergency Room Copayment is waived if the patient is admitted as an Inpatient within 24 hours to the same Hospital for treatment of the same condition.
9. **Enhanced Accidental Injury Benefit:** Payment will be made at 100% of the allowable charge for covered services associated with any and all Accidental Injuries incurred up to a maximum of $1,000 per Insured per Benefit Period.
10. **Preventive Health Benefits:** Each Insured is eligible to receive the following preventive services paid at 100% of the allowable charge when received from a Contracting Provider for preventive (i.e., not diagnostic or treatment) purposes. Preventive Health Services received from a Non-Contracting Provider will be subject to the cost-sharing requirements (including copayments, coinsurance and deductible), applicable hereunder, in a manner consistent with Section 2713 of Federal H.R. 3590 for:

    a. evidence-based items or services that have in effect, a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;

    b. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

c. with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

d. with respect to women, such additional preventive care and screenings not described in item (a) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph (including breast cancer screening and mammography screenings).

A list of the preventive services covered under this section is available on our website at www.bcbsks.com, or will be mailed to You upon request. You may request the list by calling the Customer Service number on Your Identification Card.

Note: Benefits for any prescription drug under this Preventive Health Benefits section will be provided only to the extent they are not available under other drug coverage You have through the Contract Holder.

11. **Any reduction made in allowable charges** due to the provider being non-contracting cannot be used to meet any Deductible, Coinsurance, Copayments and/or the Annual Out-of-Pocket Maximum if applicable.

12. **Mental Illness or Substance Use Disorders (Covered Services must be provided by an Eligible Provider for Mental Illness or Substance Use Disorders)**

    Benefits for Inpatient and Outpatient Mental Illness or Substance Use Disorder services that are Medically Necessary will be provided at the same payment level that is applicable to the service if it had been provided for a condition other than Mental Illness or Substance Use Disorder.

13. **Diabetic Education**

    Benefits for a covered diabetic education service will be subject to the same payment provisions as an office visit.

14. **Other Covered Services:** Unless otherwise specified, all covered services shall be subject to the applicable Deductible, Coinsurance, Copayments and/or other payment provisions described herein.

15. **Insured Responsibility:** Unless otherwise specified, all covered services shall be subject to the applicable Deductible, Coinsurance, Copayments and/or other payment provisions described herein.

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B. General

1. All coverage under this section is subject to the service having been ordered by a Professional Provider with the legal authority to order such service, furnished or performed and billed for by an Eligible Provider with the legal authority to provide such service, and is Medically Necessary.

2. You have the right to select Your own provider. However, the Company does not guarantee the availability of any service and benefits shall be provided according to the cost-containment policies and procedures applicable to Contracting Providers, regardless whether Your Provider is actually a Contracting Provider.

3. "Except as limited" is a phrase You will see before explanations of services. It is a reminder that the terms of this Certificate -- especially exclusions -- may restrict Your benefits.

4. Prior Authorization is required for some Prescription Drugs covered under this Comprehensive Program. A list of those drugs is available on www.bcbsks.com or by contacting customer service. To obtain prior authorization Your physician must provide appropriate records to the Company prior to providing services and the Company will authorize coverage if the medical necessity is supported. Failure to obtain prior authorization will not result in a denial of benefits if medical necessity is supported when the claim is adjudicated.

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C. Covered Services

1. **Hospital and Medical Care Facility services for Inpatients --** Except as limited, the following are covered:

   a. Room accommodation, dietary and general nursing service, nursery care.

      Limitation: If You occupy a private room, only the average semi-private room rate (based on the provider's rates for rooms with two or more beds) is covered.

   b. Intensive Care Unit facilities and services.

      Limitation: If You occupy an Intensive Care Unit room when it is not Medically Necessary but it is Medically Necessary for You to be in the Hospital, only the Hospital's average semi-private room rate (based on rates for rooms with two or more beds) is covered on such days.

   c. Operating room services.

d. Delivery room service. (Including the obstetrical and delivery expenses of the birth mother of a child adopted within 90 days of birth of such child).

e. Surgical preparatory and recovery room services.

f. Clinical laboratory and pathology services.

g. Diagnostic radiology services and Imaging studies.

h. Radiation therapy

i. Drugs approved for use in the United States by the U.S. Food and Drug Administration, except drugs approved for experimental use and drugs for take-home use.

j. Surgical dressings, splints, and casts.

k. Chemotherapy, other than High-Dose Chemotherapy, for malignant conditions. (See the Special Situations section for High-Dose Chemotherapy with Hematopoietic Support benefits.)

l. Prostheses that require surgical insertion into the body and are furnished and billed by the Hospital or Ambulatory Surgical Center. This does not include artificial eyes, ears, and limbs.

m. Setups for intravenous solutions.

n. Setups for blood transfusions, (including Blood plasma).

o. Oxygen and use of equipment for its administration.

p. Radioactive isotopes.

q. Electroencephalograms (EEGs) and electrocardiograms (EKGs).

r. Inhalation therapy/breathing treatment.

s. Physical or occupational therapy.

t. Anesthesia, including general anesthesia and facility charges for dental care provided to the following covered persons: (a) A child five (5) years of age and under; (b) A person who is severely disabled; (c) A person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided.

u. Hemodialysis.

v. Services for a Mental Illness or Substance Use Disorder.

Prior Authorization Requirement

Inpatient admissions to Hospitals and Medical Care Facilities require prior authorization by the Company unless the admission is for a Medical Emergency, a life-threatening condition, for obstetrical care or occurs outside the 50 United States.

You or Your Doctor will need to notify the Company to obtain the prior authorization. Notice should be given to the Company at least 72 hours in advance of the planned admission and should include: The patient's name, date of birth, identification number, telephone number, address, Hospital name, planned date of admission, reason for admission, admitting physician's name. The notification may be telephoned to the Company at the telephone number on the Insured's Identification Card.

The Company has the right to request and obtain whatever medical information it considers necessary to determine whether admission as an Inpatient is Medically Necessary. If it is, the Company will notify You, the Hospital and the admitting physician of approval. If inpatient admission is not deemed Medically Necessary You will be notified, as will be the Hospital and admitting physician. Prior authorization of an admission or any service is related solely to the medical necessity of the service and is not a determination of the eligibility of the service under other provisions of this Certificate.

If You fail to obtain a necessary prior authorization, the Company will review that admission for medical necessity. No coverage will be provided under this Program for services determined to be medically unnecessary. Only that portion of the inpatient claim that would normally be payable if services were received as an outpatient will be covered.

2. **Hospital Services for an Outpatient.**

   Except as limited, Covered Services by a Hospital for an Outpatient will include all services listed in C.1.c through v when the service is received in the Outpatient department of the Hospital.

3. **Ambulatory Surgical Center Services.**

   Except as limited, the services listed in C.1.c through u are covered when billed by an Ambulatory Surgical Center.

4. **Professional Provider Services.**

Except as limited, the following are covered:

Surgery and anesthesia services to include coverage for the administration of general anesthesia for dental care provided to the following covered persons: (a) A child five (5) years of age and under; (b) A person who is severely disabled; (c) A person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided.

Treatment of fractures and dislocations.

Biopsies and aspirations.

Endoscopic (scope) procedures.

Maternity services (including the obstetrical and delivery expenses of the birth mother of a child adopted within 90 days of birth of such child).

Medical (non-surgical) services for Inpatients in a Hospital or Medical Care Facility. (See 4.a for details of this benefit.)

Diagnostic radiology services and Imaging studies.

Diagnostic laboratory services.

Radiation therapy.

Chemotherapy, other than High-Dose Chemotherapy, for malignant conditions. (See 4.b for details of the standard chemotherapy benefit and the Special Situations section for High-Dose Chemotherapy with Hematopoietic Support benefits.)

Diagnostic radio isotope studies.

Electroencephalograms (EEGs) and electrocardiograms (EKGs).

Rehabilitation services. (See 4.d for details of this benefit.)

Home and office visits.

Immunizations, injections and infusions subject to any prior authorization requirements of this Certificate that are otherwise applicable to these services.

Allergy testing.

Transfusions (but not the cost of the blood itself).

Oral surgery and certain other dental services. (See 4.c for details of this benefit.)

Pap Smears.

Prescription contraceptive devices including placement and fitting of the device itself.

Surgical procedures for the implantation of Bone Anchored Hearing Aids (BAHA).

Services for a Mental Illness or Substance Use Disorder.

Coverage for Prostate Cancer Screening for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older. The screening may consist of a Prostate Specific Antigen (PSA) test and/or a digital rectal examination.

Coverage for services related to diagnosis, treatment and management of osteoporosis for individuals with a condition or medical history for which bone mass measurement is medically necessary for such an individual. Coverage is subject to the same Deductible, Coinsurance and other limitations as apply to other covered services.

Diagnosis and treatment of cause of infertility

a. The covered Medical (Non-Surgical) Services for Hospital or Medical Care Facility Inpatients include:

(1) Visits by the attending Doctor.

Limitations:

(a) During a stay for surgery, Medical (Non-Surgical) Services given by a Doctor other than the surgeon will not be covered unless they are Medically Necessary.

(b) If non-surgical treatment is given by two (2) or more Doctors at the same time, only one (1) Doctor will be paid for services.

(2) Consultations.

The first visit of a Doctor to give professional advice about Your condition is covered if the visit is requested by the attending Doctor and Your condition requires special skill or knowledge. This

consultation benefit is normally limited to one (1) during each Hospital stay. However, additional consultations may be approved with individual consideration of Your condition.

Consultations required by Hospital rules and regulations are not covered.

(3) Well Baby Care.

This covered service is for care of a well newborn during the mother's stay. It includes the normal Inpatient medical care for a newborn. The child must meet the applicable Deductible then this service is payable at the applicable Coinsurance amount.

b. Chemotherapy for malignant conditions.

(1) Chemotherapy administration services.

(2) Chemotherapy drugs that are injected or given intravenously or taken by mouth and under the direct supervision of Your Doctor. Prescription Drugs for chemotherapy are covered under the health benefits section of this coverage only if You are not enrolled in prescription drug coverage.

(3) Home and office visits for treatment of an adverse reaction to chemotherapy.

(4) Any other services related to chemotherapy that are specifically stated as covered.

c. Oral Surgical Services and Services for Accidental Injuries to Sound Natural Teeth, limited to:

(1) Surgical procedures of the jaw and gums.

(2) Removal of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

(3) Removal of exostoses (bony growths) of the jaw and hard palate.

(4) Treatment of fractures and dislocations of the jaw and facial bones.

(5) Surgical removal of impacted teeth.

(6) Treatment (including replacement) for damage to or loss of Sound Natural Teeth caused by an Accidental Injury.

(7) Intra oral dental imaging services in connection with covered oral surgery if such oral surgery occurs within 30 days of the imaging service(s.)

(8) General anesthesia.

(9) Cylindrical endosseous dental implants, mandibular staple implants, subperiosteal implants and the associated fixed and/or removable prosthetic appliance when provided because of an Accidental Injury.

(10) Cylindrical endosseous dental implants, mandibular staple implants, subperiosteal implants and the associated fixed and/or removable prosthetic appliances following surgical resection of either benign or malignant lesions (NOT including inflammatory lesions).

Exclusions: The extraction of teeth (except impacted teeth); fillings; prophylaxis (cleaning); scaling, scraping and/or root planing; dentures; straightening of teeth; and other dental services not listed as covered.

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d. Covered Rehabilitation Services. Except as limited, the following Rehabilitation Services are covered on both an Inpatient and Outpatient basis:

(1) Physical medicine modalities, including but not limited to: correction or adjustment by manual, mechanical, electrical or physical means (including the use of light, heat, water or exercise) of structural imbalance, distortion, subluxation or displaced tissue of any kind or nature of the human body.

(2) Physical therapy.

(3) Occupational therapy. (The materials used are excluded.)

(4) Speech therapy, limited to one service per day up to a maximum benefit of 90 daily services per Insured per Benefit Period. This limitation is not applicable to Mental Illness or Substance Use Disorders.

(5) Respiratory therapy.

(6) Neuropsychological testing.

(7) Cardiac Rehabilitation program or provider approved by the Company.

(8) Pulmonary rehabilitation program or provider approved by the Company.

Limitations:

(1) Services are covered only if they are expected to result in significant improvement in the Insured's condition. The Company, with appropriate medical consultation, will determine whether significant improvement has occurred.

(2) Cardiac and pulmonary rehabilitation programs are covered services only when provided by a provider whose program has been approved by the Company. You can obtain a list of approved programs, by calling the Customer Service number on Your Identification Card.

Exclusions:

(1) Vocational rehabilitation. Vocational rehabilitation is a process to restore or develop the working ability of the physically, emotionally or mentally disabled patients to the extent that they may become gainfully employed. This may include services provided to determine eligibility or provide treatment for vocational rehabilitation, to include but not limited to counseling, work trials and driving lessons.

(2) Therapies designed to evaluate and assist an individual in developing a program to complete their work and prevent physical damage or reinjury.

(3) Cognitive therapy. Cognitive therapy is a service provided to retain or enhance information processing due to brain damage or brain dysfunction which alters the way in which a person perceives or responds. These therapies include, but are not limited to treatment of memory loss, problem solving difficulties, short attention span, or inability to scan visually. Cognitive therapy services may also be known as multi-sensory programs, applied behavioral analysis, educational therapies, perceptual therapies, sensory integration, auditory integrative training, augmentative/alternative communication, discrete training trials, developmental therapy, or similar therapies. For the purposes of this Certificate, cognitive therapy services do not include neuropsychological testing.

e. Services for Autism Spectrum Disorder

(1) Definitions:

- Applied Behavior Analysis (ABA) means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior;
- Autism Spectrum Disorder (ASD) means a neurobiological disorder which includes autistic disorder, Asperger's disorder, pervasive developmental disorder not otherwise specified, Rett's disorder, and childhood disintegrative disorder when diagnosed by a licensed physician, licensed psychologist, or licensed specialist clinical social worker.

(2) Covered Services:

- ASD services include:
  - diagnostic evaluations performed by a licensed physician, licensed psychologist or licensed specialist clinical social worker;
  - treatment, including ABA therapy, limited to care, services, and related equipment prescribed or ordered by a licensed physician, licensed psychologist or licensed specialist clinical social worker;
- ABA therapy is limited to 1,300 hours per benefit period for four years beginning on the later of the date of diagnosis or January 1, 2015, for any covered individual diagnosed with Autism Spectrum Disorder between birth and five years (prior to the attainment of 60 months) of age; and
- 520 hours of ABA therapy per benefit period for any covered individual less than 12 years of age.
- Only those services actually provided on an hourly basis or fractional portion thereof by certified ABA providers are covered.
- ABA therapy services require prior authorization by the Company. You or Your doctor will need to notify the Company to obtain prior authorization. Notice should be given to the Company at least 72 hours in advance of the planned ABA therapy services and should include: the patient's name, date of birth, identification number, telephone number, address, the name of the prescribing physician, psychologist or licensed clinical specialist social worker and the date the patient was first diagnosed with autism spectrum disorder.

  The Company has the right to request and obtain whatever medical information it considers necessary to determine whether the ABA therapy services are Medically Necessary. If it is, the

Company will notify You and the treating provider of approval. If ABA treatment is not deemed Medically Necessary You and the treating provider will be notified.

If You fail to obtain a necessary prior authorization, the Company will review the ABA services for medical necessity. No coverage will be provided under this Program for services determined to be medically unnecessary.

(3) Exclusions:

- Full or partial day care or habilitation services, community support services, services at intermediate care facilities, school-based rehabilitative services, or overnight, boarding and extended stay services at facilities for autism patients; or
- Services that are otherwise provided, authorized or required to be provided by public or private schools receiving any state or federal funding for such services.

5. **Other Covered Services.**

Except as limited, the services listed below are covered:

a. Orthopedic, orthotic and prosthetic devices and appliances, including orthopedic braces, artificial limbs, artificial eyes, auditory osseointegrated devices.

Limitations:

(1) Benefits are not provided for eyeglasses and contact lenses.

Exception

- Benefits are available for the initial eyeglasses/contacts following surgery for cataracts, aphakia, or pseudophakia.
- An Insured under 12 years of age is eligible for subsequent eyeglasses/contacts following cataract surgery when there is a minimum change of .25 diopter.

(2) Benefits are not provided for hearing aids, hair prosthesis or dental appliances including plates, bridges, prostheses or braces.

(3) Benefits are not provided for items of wearing apparel except coverage is available for two post-mastectomy bras per Insured per Benefit Period. A post-mastectomy bra is a bra that is specifically designed and intended to support single or bilateral breast prostheses.

(4) Benefits are limited to the allowable amount for a basic/standard appliance which provides the essential function(s) required for the treatment or amelioration of the medical condition.

(5) Charges for deluxe or electrically operated appliances or devices are not covered beyond the allowable amount for basic/standard appliances. Deluxe describes medical devices or appliances that have enhancements that allow for additional convenience or use beyond that provided by a basic/standard device or appliance.

(6) Benefits are not provided for custom or over-the-counter orthotic devices, appliances including shoe inserts.

b. Medical Equipment and Supplies. Equipment for use in Your home is covered if:

- Prescribed by a Doctor for use in the home
- Not provided by a Hospital
- Serves a medical purpose
- Not an item that would ordinarily be of use to a person in the absence of a medical need. This includes items such as hemodialysis equipment, wheelchairs and hospital-type beds.

Medical Supplies: Coverage is also available for certain supplies as designated by the Company. You can obtain a list of covered supplies by contacting Customer Service at the number listed on Your Identification Card.

Limitations:

(1) Items for comfort or convenience are not covered. Included within the definition of convenience items are:

(a) Pieces of equipment used to provide exercise to functioning and non-functioning portions of the body when leased, purchased, or rented for use outside a recognized institutional facility.

(b) Those pieces of equipment designed to provide the walking capability for individuals with non-functioning legs

(2) The Company has the right to decide whether to provide for the rental or purchase of a covered item, to apply rental payments to purchase, and to stop covering rental when the item is no longer Medically Necessary.

(3) Benefits are limited to the allowable amount for a basic/standard item which provides the essential function(s) required for the treatment or amelioration of the medical condition.

(4) Charges for deluxe or electrically operated medical equipment are not covered beyond the allowable amount for basic/standard items. Deluxe describes medical equipment that has enhancements that allow for additional convenience or use beyond that provided by basic/standard equipment. For example, if an electric wheelchair is obtained, the benefit will not exceed the amount for a hand-operated wheelchair.

c. Allergy Antigens

d. Services associated with intravenous drug treatment including prescription drugs, supplies, and equipment and nursing services by Infusion Therapy Providers.

e. Diabetic Management.

(1) Equipment used exclusively with diabetes management.

Limitations:

Benefits are limited to the allowable amount for a basic/standard item; charges for deluxe items are not covered.

(2) Supplies: Coverage for diabetic supplies is provided under the Comprehensive Program only if the Insured does not have prescription drug coverage for such supplies. For purposes of this provision, diabetic supplies means syringes, needles, lancets, test strips and solutions, calibration strips, solutions and insulin pump supplies used exclusively with diabetic management.

(3) Outpatient self-management training and education, including medical nutrition therapy, for insulin dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes when provided by a certified, registered or licensed health care professional with expertise in diabetes and the diabetic (1) is treated at a program approved by the American Diabetes Association or American Association of Diabetes Educators; (2) is treated by a person certified by the national certification board of diabetes educators; or (3) is, as to nutritional education, treated by a licensed dietitian pursuant to a treatment plan authorized by such healthcare professional.

f. Genetic Molecular Testing only in the following situations:

(1) When there are signs and/or symptoms of an inherited disease in the affected individual, there has been a physical examination, pre-test counseling, and other diagnostic studies, and the determination of the diagnosis in the absence of such testing remains uncertain and would impact the care and management of the individual on whom the testing is performed.

(2) BRCA 1 and/or BRCA 2 testing when there are signs and/or symptoms of an inherited disease as specified above, or when signs and/or symptoms are not present but the testing has been prior authorized according to the criteria established by the Company.

As used herein, "Genetic Molecular Testing", means analysis of nucleic acids used to diagnose a genetic disease, including but not limited to sequencing, methylation studies and linkage analysis.

6. **Emergency Services.** Services necessary to provide an Insured with evaluation and stabilizing treatment when provided for a Medical Emergency.

7. **Ambulance Service.**

Except as limited, Ambulance Services that are Medically Necessary are covered:

- To the place of treatment following an Accidental Injury or Medical Emergency
- To a Hospital for care as an Inpatient
- From a Hospital where You have been an Inpatient
- For transfer of an Inpatient to another Hospital for care as an Inpatient.
- A 500-mile radius of the place where You are picked up, by the least expensive means or transport that meets the medical need.

D. Special Situations

1. **Case Management**

Case Management is a process conducted by the Company which:

a. identifies cases involving an Insured which presents either the potential for catastrophic claims or a utilization pattern that exceeds the norms and demonstrates or has the potential for atypical utilization of services;

b. assesses such cases for the appropriateness of the level of patient care and the setting in which it is received;

c. reviews services requested by the provider for potential alternative use of benefits or coordination of existing benefits; and

d. evaluates and monitors the requested services for cost efficient use of benefits.

The services may include both covered services and non-covered services with the exception of specifically stated exclusions. Total benefits paid for such services shall not exceed the total benefits to which the Insured would otherwise be entitled under the terms of this Certificate.

If the Company elects to provide benefits for an Insured in one case, it shall not obligate the Company to provide the same or similar benefits for the same or another Insured in the same or another case.

Participation in Case Management is voluntary. The Insured may withdraw at any time and return to the stated benefits of this Certificate.

2. **Research-Urgent Benefits.** Drugs, devices, medical treatments or procedures that are otherwise excluded as Experimental or Investigational but meet the criteria for Research-Urgent benefits as provided in the General Definitions section. No benefits shall be available under this section for any Research-Urgent drug, device, medical treatment or procedure (or related services) that are provided free of charge to trial participants or for any Research-Urgent drug, device, medical treatment or procedure that are excluded by another provision of this Certificate.

3. **Penile Prosthesis for Physiological Impotence.**

Benefits are provided for a penile prosthesis required for physiological (not psychological) impotence, subject to advance approval by the Company only in the following situations: trauma, radical pelvic surgery, diabetes, Peyronie's Disease, vascular or neurological diseases when individual situation warrants coverage in the Company's opinion.

To request advance approval, a written report prepared by Your Doctor must be submitted to the Company. The Company has the right to request and obtain medical information it considers needed to determine whether benefits should be approved or not.

Benefits are not provided for services of sleep laboratories for nocturnal penile tumescence testing.

4. **Home Health Care and Private Duty Nursing Services**

Covered Home Health Care services include services provided by a Medicare certified Home Health Agency.

An Insured must be homebound for the following services to be eligible. An Insured will be considered to be homebound if they have a condition due to illness or injury for which leaving the home is medically contraindicated. The Company has the right to determine whether the patient is homebound.

All Home Health Care and Private Duty Nursing services require Prior Authorization by the Company in order to be eligible for benefits. If prior approval is not obtained, the Company has the right to request medical records to review to determine whether services are eligible under this Certificate.

a. Covered Services include:

1. Nursing care provided in the Insured's home by:

- A Registered Nurse
- A Licensed Practical Nurse
- A licensed vocational nurse

2. Services provided in the Insured's home by a Licensed Social Worker.

3. Private Duty Nursing services provided by a state licensed nursing agency or state licensed nurse for Medically Necessary services provided on an hourly basis to a homebound Insured.

b. Covered Services do not include services:

- Provided by a member of the Insured's immediate family;
- Provided by a person who normally lives in the Insured's home; or
- Which are Custodial/Maintenance care. The Company has the right to determine which services are Custodial/Maintenance care.

c. Services that do not require that the patient be homebound.

- Home care education associated with diabetes, colostomy care, wound care, IV therapy, or any other condition or treatment which the Company has determined is appropriate for home care education, when provided by a Medicare certified Home Health Agency. Benefits for educational services will be limited to no more than three home care education visits per Benefit Period for which home care education is appropriate.
- Home infusion and related services. These services can be provided by either a Medicare certified Home Health Agency, state licensed nursing agency or state licensed nurse.

5. **Hospice Care**

Definitions

a. **Hospice Care Plan** means a coordinated plan of care which provides Palliative Care for the Hospice Patient. This plan is designed to provide care to meet the special needs during the final stages of a terminal illness.

b. **Palliative Care** means treatment directed at controlling pain, relieving other physical and emotional symptoms and focusing on the special needs of the Hospice Patient and the Hospice Patient's Family, as they experience the dying process rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

c. **Hospice Patient's Family** means the Hospice Patient's immediate family, including a spouse, brother, sister, child or parent. Other relations and individuals with significant personal ties to the Hospice Patient may be designated as members of the Hospice Patient's Family by mutual agreement among the Hospice Patient, the relation or individual and the Hospice Team.

d. **Hospice Patient** means a patient diagnosed or referred by a physician, to a Hospice and who alone, or in conjunction with designated family members, has requested and received admission into a hospice program. Written certification by the patient's Doctor that the Hospice Patient has a life expectancy of 6 months or less is required.

e. **Hospice Team or Interdisciplinary Group** means the attending physician and the following hospice personnel: physician, registered or licensed practical nurses, licensed social workers, pastoral or other counselors. Providers of special services, such as mental health, pharmacy, home health aides, trained volunteers and any other appropriate allied health services shall also be included on the Interdisciplinary Group as the needs of the patient dictate.

Election of Hospice Benefits

In order for You to receive Hospice benefits for the covered services listed below, the Company must receive a copy of a hospice election form and the informed consent form from a Medicare certified Hospice. If these forms are not received, benefits of this Hospice Care provision will not be available and services You receive will be processed according to the benefits and limitations of this Certificate other than those listed in this Hospice Care provision.

All Hospice Care services require prior authorization by the Company in order to be eligible for benefits. If prior approval is not obtained, the Company has the right to request medical records for review to determine whether services are eligible under this Certificate.

Eligibility of Services

a. Once Hospice benefits are elected, coverage for the terminal illness and related conditions is limited to the coverage listed in this Hospice Care provision unless specified otherwise.

b. Coverage under this Hospice Care provision is available only for Palliative Care. If Blue Cross and Blue Shield of Kansas determines the care provided is not Palliative Care, benefits of this Hospice Care provision cease to be available.

c. When covered services are not available from a Hospice provider (for example individual psychotherapy services) and the Insured is referred to another provider of service, benefits are not available under this Hospice Care provision, except as provided under the description of Covered Services.

In situations b. and c. listed above when services are not eligible for benefits under the Hospice Care provision, the services will be processed according to the benefits and limitations of this Certificate other than those listed in this Hospice Care provision.

Covered Services

Covered Hospice Care includes the following services provided by a Medicare certified Hospice (or an Institutional or Professional Provider under the direction of a Medicare certified Hospice and not charging

for services separately from the Hospice). Covered services also include the following when provided for routine home care according to the Hospice Care Plan:

a. Nursing care.
b. Home health aide services.
c. Social work services.
d. Pastoral services.
e. Volunteer support.
f. Bereavement services.
g. Counseling services.
h. Dietary and nutritional counseling/services.
i. All drugs, medical supplies, and equipment related to the terminal illness.
j. Speech therapy.
k. Occupational therapy.
l. Physical therapy.
m. Lab fees.
n. Medical equipment.
o. Educational services.
p. Other services and supplies provided through the Medicare certified Hospice (excluding Inpatient Hospital care and Inpatient or Outpatient physician's visits) recommended by a Doctor.

6. **Human Organ or Human Tissue Transplants.**

Benefits are provided (subject to the prior authorization provision set forth below) for the following human organ transplants:

- Cornea
- Heart
- Heart-lung
- Kidney
- Pancreas
- Liver
- Lung (whole or lobar, single or double)
- Small intestine
- Mulitvisceral transplants

There is no coverage hereunder for any transplant not specifically listed as covered or for supplies or services provided directly for or relative to human organ transplants not specifically listed as covered. No benefits will be provided for multiple organ transplant combinations not listed even when one or more of the organs involved is listed as a covered transplant.

Benefits for a human organ transplant will be available for a live donor (whether or not an Insured), if the recipient is an Insured, unless the donor has other coverage.

NOTE: See Prior Authorization Requirement below.

7. **High-Dose Chemotherapy with Hematopoietic Support (commonly referred to as bone marrow transplant and/or peripheral stem cell transplant).** Benefits are available only when precertified and the treatment particular for the Insured's condition is not Experimental or Investigational.

Benefits will be available for the costs associated with the donor search and acquisition of bone marrow or peripheral stem cells when a related donor is not available.

NOTE: Prior Authorization Requirement for Human Organ or Human Tissue Transplants and High-Dose Chemotherapy with Hematopoietic Support

Human organ and human tissue transplants (except cornea transplants), and high-dose chemotherapy with hematopoietic support, require advance written authorization from the Company.

You or Your Doctor must give written notice to the Company at the time as You become a candidate for a human organ transplant or re-transplant or for the high-dose chemotherapy with hematopoietic support.

The Company has the right to require, request and obtain information from Your Doctors and other health care providers involved in the performance of the transplant or re-transplant or the high-dose

chemotherapy procedure with hematopoietic support, and to determine whether or not to authorize benefits based on such information.

The Company's determination of whether or not to authorize benefits will be based on factors such as (but not limited to):

- Provider and facility qualifications
- Comparative costs of the proposed providers and facility

Notwithstanding any contradictory provisions in this document addressing allowable amounts, the Company reserves the right to limit benefits to the lowest allowable amount including organ or tissue acquisition cost which would be accepted by another facility that contracts with the Company to provide these services. Any balance will be the obligation of the Insured.

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8. **Temporomandibular Joint Dysfunction Syndrome.**

a. **Definitions.** For the purposes of this Certificate, the following terms have these meanings:

(1) Temporomandibular Joint Dysfunction Syndrome (TMJ) means a condition involving misalignment or imbalance in the relationship of the person's lower jaw (mandible) to the upper jaw (maxilla), with related spasm of the muscles of mastication (chewing). In this Certificate the terms Craniomandibular Cervical Pain (CRMP), Craniomandibular Facial Pain (CMFP), or Myofascial Pain Dysfunction Syndrome (MFPD) shall have the same meaning and benefits as Temporomandibular Joint Dysfunction Syndrome.

(2) "Treatment Plan" means Your dentist's written report of recommended treatment.

b. **Benefits for Temporomandibular Joint (TMJ) Dysfunction Syndrome**

To the extent this Certificate provides benefits for office visits, diagnostic dental imaging services, etc. for medical conditions, the following services are also covered under the medical (not dental) coverage of this Certificate, applying appropriate Deductibles, Coinsurances, Copayments/Copays, shared payments:

(1) Only one of the following are eligible for benefits and will be subject to the Home or Office Visit payment provisions:

(a) A clinical evaluation, to include examination, history, ordering of necessary diagnostic procedures (such as radiographs, study models if necessary, muscle testing), evaluation of results and consultation with the patient.

(b) A total diagnostic evaluation including, but not limited to, history, examination, radiographs, study models and a patient consultation.

(2) Diagnostic services, including but not limited to:

- Panoramic radiographs
- Cephalometric radiographs with tracing
- Temporomandibular joint tomography
- Temporomandibular joint arthrography
- Skull series; computerized tomography of temporomandibular joint
- Manual muscle testing procedures; and

One of the following:

- Electromyography of cranial supplied nerves
- Electronic computerized neuromuscular testing
- Oscilloscopic neuromuscular testing

The maximum benefit payment (after application of any payment provisions) will be the Company's allowable amount for conventional electromyography, or neuromuscular-type test.

(3) Non-surgical initial treatment procedures (reversible Phase I) limited to:

(a) Orthopedic repositioning appliances (maxillary or mandibular).

(b) Orthopedic (orthotic) splints (such as nite-guards, biteblocks, bite openers, bite plates, muscle de-programmer).

(c) Physical therapy procedures (limited to transcutaneous electrical nerve stimulators, Galvanic stimulation, ultrasound, diathermy).

(d) Trigger point injections.

These services are subject to the provisions of the Insured's medical benefits program.

Exclusions: benefits do not include:

- Equilibration of occlusion
- Coronoplasty
- Occlusal adjustment
- Slides and/or photographs
- Non-prescription drugs
- Vitamins
- Nutrition supplements
- Stretching and other exercises
- Coolant sprays
- Rental or purchase of transcutaneous electrical nerve stimulators
- Office visits
- Periapical, bitewing and full-mouth radiographs
- Moist heat therapy
- Hot packs
- Massage, either manual or by machine
- Acupuncture
- Cold packs
- Range of motion treatments
- Diet survey
- Nutrition counseling
- Orthodontic treatment, including both fixed and removable appliances used for the purpose of moving teeth

(4) Surgical procedures, subject to the appropriate Deductible, Coinsurance, Copayment/Copay, and shared payments of this Certificate, must be prior authorized by the Company based on a Treatment Plan. Requests for authorization will be reviewed based on: diagnosis (the condition must be treatable by surgery); the patient's age; presence of debilitating pain; efficacy of conservative treatment; diagnostic records and description of the proposed surgical procedure.

(5) Final stabilization non-surgical (Irreversible Phase II) treatment.

Benefits for Phase II services, such as appliances, crowns and replacement of missing teeth, may be covered under Your Dental Care Program. If You do not have a Dental Care Program, there are no benefits for these services.

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PRESCRIPTION DRUG PROGRAM

A. General

1. Benefits of the Prescription Drug Program apply to Insureds enrolled for such coverage under the Certificate.
2. **Company Not Liable.** The Company will not be liable for any acts or wrongs of any party related to the sales, compounding, dispensing, manufacturing, or use of any Prescription Drug or insulin. This includes any claim, injury, demand, or judgment based on tort or other grounds (including warranty of merchantability).
3. **Your Pharmacy.** You have the right to select Your own Pharmacy. However, the Company does not guarantee the availability of any drug or supply and does not itself furnish Prescription Drugs. Also, coverage may be limited or unavailable for certain Pharmacies or Specialty Pharmacies as provided below.

B. Definitions

1. **Brand** means a Prescription Drug that is or has been marketed under patent protection.
2. **Compound** means a Prescription Drug: a) that is manufactured by a Pharmacy when no suitable commercial alternative is available; b) for which the main active ingredient is a covered Prescription Drug; and c) for which the purpose is solely to prepare a dose form that is Medically Necessary.
3. **Copayment** means the portion of the charge for a covered Prescription Drug You are responsible for each time Your Prescription Order is filled or refilled.
4. **Diabetic Supplies** means syringes, needles, lancets, test strips and solutions, calibration strips, solutions, and insulin pump supplies used exclusively with diabetic management.
5. **Formulary** means a list of both Brand and Generic Prescription Drugs reviewed and updated by the Pharmacy Benefit Manager and Therapeutics Committee which is comprised of physicians and Pharmacists. Prescription Drugs are selected for inclusion on the Formulary based on safety, efficacy and cost effectiveness. The Formulary is subject to periodic review and modification.

   The Formulary applies only to Prescription Drugs covered under this Program. The Formulary does not apply to Inpatient medications or to medications administered by a Professional Provider. The level of benefits You receive under this Program will be affected by a Prescription Drug's Generic/Brand status on the Formulary.

   To access the Formulary, visit our website at www.bcbsks.com or call Customer Service at the telephone number listed on Your Identification Card.
6. **Generic** means a Prescription Drug that: a) is equivalent to a Brand Drug, b) is available after the patent on that Brand Drug has expired and c) is available from more than one source. Equivalent means therapeutic equivalent as determined by the U.S. Food and Drug Administration.
7. **Pharmacist** means a person registered or licensed under his or her State's laws to dispense Prescription Drugs and/or administer vaccines and immunizations.
8. **Pharmacy** means an establishment registered or licensed where Prescription Drugs are dispensed by a Pharmacist. Pharmacies are further classified as:
   a. **Contracting Pharmacy** means a Pharmacy which has entered into a written network participation agreement with Blue Cross and Blue Shield of Kansas and/or a Pharmacy Benefit Manager.
   b. **Contracting Specialty Pharmacy** means a Contracting Pharmacy which has entered into a written network participation agreement with Blue Cross and Blue Shield of Kansas and/or a Pharmacy Benefit Manager to provide Specialty Prescription Drugs.
   c. **Non-Contracting Pharmacy** means a Pharmacy which has not entered into a written network participation agreement with Blue Cross and Blue Shield of Kansas or a Pharmacy Benefit Manager.
9. **Pharmacy Benefit Manager (PBM)** means an entity with which Blue Cross and Blue Shield of Kansas contracts for the provision of administrative, utilization review and network services for the covered drug and supplies under this Program.
10. **Prescription Drug** means a drug approved for general use in the United States by the U.S. Food and Drug Administration, assigned a National Drug Code (NDC) number and dispensed in compliance with federal or state laws pursuant to a Prescription Order or refill.
11. **Prescription Order** means the request Your Doctor may legally issue for a Prescription Drug.
12. **Prior Authorization** is the process of obtaining approval for certain Prescription Drugs based on criteria established by the Company. Prior Authorization is required for some Prescription Drugs covered under this

Program. Prescription Drugs requiring Prior Authorization are listed on the Formulary. Prescription Drugs may be added or deleted from the list on a quarterly basis.

13. **Specialty Prescription Drug** means Prescription Drugs or classes of Prescription Drugs that are designated by the Company as Specialty Drugs. These include, but are not limited to, drugs that are self-administered by injection, inhaled or taken orally; drugs that may require special handling and storage; drugs that may require strict compliance and patient support; and drugs that may be available through limited distribution arrangements. The list of Specialty Prescription Drugs is on the Formulary.
14. **Utilization Review** means a claims review process of medical necessity. It includes the review of the medical need for prescription and quantity prescribed and the Prescription Orders to verify that Prescription Drugs were dispensed as ordered.

C. Amount of Benefits

The Copayment amounts are:

Insulin	$15.00
Generic Prescription Drug	$15.00
Brand Formulary Prescription Drug	$30.00
Brand Non-Formulary Prescription Drug	$45.00
Compound Prescription Drug	$45.00

Preventive Immunizations (as described in Preventive Health Benefits in the Comprehensive Program section of this document) are paid at 100% of the allowable charge when received from a Network Provider.

Annual Out-of-Pocket Maximum: The Annual Out-of-Pocket Maximum in the Comprehensive Program section is applicable to Prescription Drug benefits. Out-of-Pocket expenses include the Deductible, Coinsurance and/or Copayment provisions under the Comprehensive Program and Prescription Drug Program.

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D. Covered Services

Except as limited, Prescription Drugs are covered when ordered by Your Doctor and dispensed by a Pharmacy based on a Prescription Order.

The covered Prescription Drug services include:

1. The filling of the initial Prescription Order.
2. Refills of the Prescription Order as authorized by Your Doctor within one year from the date of the initial Prescription Order but not before at least two-thirds (2/3) of the previously purchased supply has been exhausted. Authorization for an early refill to accommodate a vacation supply may be obtained by contacting the Company, but not more often than two times per Insured during any 12-month period.
3. The reissue of a Prescription Order by Your Doctor for a medication previously ordered, but not before at least two-thirds (2/3) of the previously purchased supply has been exhausted. Authorization for an early reissue to accommodate a vacation supply may be obtained by contacting the Company, but not more often than two times per Insured during any 12-month period.

Limitations:

a. The benefit for Prescription Drugs pursuant to a Prescription Order shall be limited to a supply sufficient for 34 consecutive days of therapy based on criteria established by the Company, except Prescription Drugs designated by the Company, that are prescribed for certain chronic conditions, may be dispensed in supplies up to a maximum of 100-unit dose quantities, but not to exceed a supply sufficient for 100 consecutive days of therapy, if such is greater than a 34 consecutive day supply.

b. Prior Authorization is required for some Prescription Drugs covered under this Program.

c. A Pharmacy is not required to fill a Prescription Order which in the Pharmacist's judgment should not be filled.

d. Coverage for Specialty Prescription Drugs will be limited to a supply sufficient for 34 consecutive days of therapy. These Prescription Drugs are listed on the Formulary. A list of these Prescription Drugs may also be obtained by contacting Customer Service at the number listed on Your Identification Card. Prescription Drugs may be added or deleted from the list on a quarterly basis.

e. Some excluded Prescription Drugs are listed on the Formulary. These exclusions are in addition to drugs or classes of drugs excluded under other provisions of this Certificate.

4. Growth hormone therapy is covered only under one of the following circumstances:

If under age 18 and diagnosed with:

a. Both laboratory proven growth hormone deficiency or insufficiency and significant growth retardation; or

b. Substantiated Turner's Syndrome, Prader-Willi Syndrome, or Noonan's Syndrome with significant growth retardation; or

c. Chronic renal insufficiency and end stage renal disease with significant growth retardation prior to successful transplantation; or

d. Panhypopituitarism; or

e. Neonatal hypoglycemia related to growth hormone deficiency.

If age 18 and over with:

a. Evidence of pituitary or hypothalamic disease or injury and laboratory proven growth hormone deficiency; or

b. A history of prior growth hormone therapy for growth hormone deficiency or insufficiency in childhood and laboratory confirmation of continued growth hormone deficiency.

Children, Adolescents and Adults:

a. AIDS wasting syndrome

b. Short bowel syndrome

c. Severe burn patients

5. Diabetic Supplies and Insulin

6. Oral Anticancer Medication used to kill or slow the growth of cancerous cells. Such medication is covered at 100 percent of the allowable charge.

7. Psychotherapeutic drugs used for the treatment of Mental Illness and Substance Use Disorders under terms and conditions not less favorable than coverage provided for other Prescription Drugs.

8. Generic oral contraceptives will be covered at 100%.

9. Off-label Prescription Drugs used for the treatment of cancer.

E. Payment of Benefits

Subject to the payment provisions of this Prescription Drug Program, benefits are based on the following allowable charges:

1. **Contracting Pharmacies** -- The allowable charge for a covered Prescription Drug is established under the applicable network participation agreement. The allowable charge minus the Copayment will be paid directly to the Pharmacy.

2. **Non-Contracting Pharmacies** -- The allowable charge is the lesser of the Pharmacy's actual charge for the covered Prescription Drug or the allowable charge had the order been filled by a Contracting Pharmacy. You are responsible for the Copayment and any difference between the actual charge and the allowable charge.

Benefits will be paid to the Insured. Such benefits are personal to that Insured and cannot be assigned to any other person or entity.

NOTE: If You obtain a Prescription Drug from a Contracting Pharmacy and do not, at that time, notify the Pharmacy that You are eligible for Prescription Drug benefits through this Program the Prescription will be considered as having been provided by a Non-Contracting Pharmacy.

F. Exclusions

Benefits are not provided for:

1. Prescription Drugs for which normally (in professional practice) there is no charge.

2. Prescription Drugs for other than human use.

3. Orthopedic or prosthetic appliances and devices.

4. Prescription Drugs purchased from an institutional pharmacy for use while the Insured is an Inpatient in that institution.

5. Charges for delivering any drugs.
6. Any drug prescribed or dispensed in a manner that does not agree with generally accepted medical or pharmaceutical practices.
7. Drugs, supplies, and equipment used in intravenous treatment.
8. Benefits are not available to the extent a Prescription Drug has been covered under another contract, certificate, or rider issued by Blue Cross and Blue Shield of Kansas.
9. Allergy antigens.
10. Any food item, including breast milk, formulas and other nutritional products.
11. Total parenteral nutrition.
12. Drugs available over-the-counter in the equivalent dose which do not require a Prescription Order under federal or state law except those covered under the Preventive Health Benefits section.
13. Charges for services that are not listed as covered services.
14. Services for injuries or diseases related to Your employment to the extent You are covered or are required to be covered by a worker's compensation law. If You enter into a settlement giving up Your right to recover past or future medical benefits under a worker's compensation law, the Company will not pay past or future medical benefits that are the subject of or related to that settlement.

    In addition, if You are covered by a worker's compensation program which limits benefits when other than specified providers are used, and You receive services from a provider not specified by the program, the Company will not pay balances of charges from such non-specified providers after Your benefits under the program are exhausted.
15. Services in which duplicate benefits are available under federal, state, local laws, regulations or programs. Examples of such programs are: Medicare; TRICARE; services in any veteran's facility when the services are eligible for coverage by the government. This Certificate will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid.

    This exclusion applies whether or not You choose to waive Your rights to these services except for those services that would be eligible for benefits under Medicare Part D prescription drug coverage. Such benefits shall only be excluded if You are enrolled in Part D.
16. Any service provided through a district pursuant to an Individual Education Plan (IEP) as required under any federal or state law. This exclusion applies whether or not You choose to waive Your rights to these services.
17. Health services associated with accidental bodily injuries arising from a motor vehicle accident to the extent such services are payable under medical expense payment provision of any automobile insurance policy.
18. Services not prescribed by a Doctor or continued after a Doctor has advised that further care is not necessary.
19. Services that are not Medically Necessary, as defined in this Certificate.
20. Prescription Drugs utilized primarily for stimulation of hair growth. This exclusion applies even if the drug is prescribed for purposes other than the stimulation of hair growth.
21. Charges for completion of insurance claim forms.
22. Any drug, device or medical treatment or procedure and related services that are, as of the date of service, Experimental or Investigational as defined in the General Definitions section. This exclusion does not apply to routine patient care services (as defined in Kansas Administrative Regulation 40-4-43) provided in an approved cancer clinical trial for which benefits would otherwise be available for the same services when not provided in connection with such clinical trial.
23. Services provided directly for or relative to diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion, or aggression.
24. Any drug or supply associated with the medical management and treatment of obesity. This includes, but is not limited to, nutrients and Prescription Drugs prescribed for purposes other than the treatment of obesity.
25. Appetite suppressants.
26. Any service or supply provided or obtained relative to an excluded service. "Provided relative to" refers to any service or supply which would not have been provided or obtained if the excluded service would

not have been provided and which is provided on whether an Inpatient or Outpatient basis by any Eligible Provider.

27. Growth hormone therapy or other drugs used to treat growth failure except in those situations specifically set out as eligible for benefits.
28. Certain Prescription Drugs that have therapeutically equivalent or interchangeable drugs that are available over the counter (OTC) and may be obtained without a Prescription Order. This would include drug products from the same therapeutic class containing different chemical entities, but which would provide similar effects or the same pharmacological action when administered in therapeutically equivalent doses. These drugs are listed on the Formulary.
29. Prescription Drugs listed as excluded on the Formulary. Such exclusions are in addition to drugs or classes of drugs excluded under other provisions of this Certificate.

Form RX-737ng 1/15

MAIL ORDER PRESCRIPTION DRUG PROGRAM

A. General

The Company has contracted with a Mail Order Pharmacy to make available to eligible Insureds, Prescription Drugs subject to the provisions of this Mail Order Prescription Drug Program. The benefits specified in this Mail Order Prescription Drug Program are only applicable to Prescription Drugs ordered through the Mail Order Pharmacy. Nothing in this Mail Order Prescription Drug Program requires You to utilize the Mail Order Pharmacy when filling an order for a Prescription Drug.

NOTE: All products may not be available from the Mail Order Pharmacy. The Mail Order Pharmacy may determine that certain Prescription Drugs will not be dispensed by the Mail Order Pharmacy when the product cannot be safely delivered to the Insured's home, the product is not available to the Pharmacy or the product is not commercially available.

B. Definitions

1. **Brand** means a Prescription Drug that is or has been marketed under patent protection.
2. **Compound** means a Prescription Drug: a) that is manufactured by a Pharmacy when no suitable commercial alternative is available, b) for which the main active ingredient is a covered Prescription Drug and c) for which the purpose is solely to prepare a dose form that is Medically Necessary.
3. **Copayment** means the portion of the charge for a covered Prescription Drug You are responsible for each time Your Prescription Order is filled or refilled through the Mail Order Pharmacy. . The amount of Copayment is determined by whether the order is filled with a Generic or with a Brand Drug.
4. **Diabetic Supplies** means syringes, needles, lancets, test strips and solutions, calibration strips, solutions, and insulin pump supplies used exclusively with diabetic management.
5. **Formulary** means a list of both Brand and Generic Prescription Drugs reviewed and updated by the Pharmacy Benefit Manager and Therapeutics Committee which is comprised of physicians and Pharmacists. Prescription Drugs are selected for inclusion on the Formulary based on safety, efficacy and cost effectiveness. The Formulary is subject to periodic review and modification.

   The Formulary applies only to Prescription Drugs covered under this Program. The Formulary does not apply to Inpatient medications or to medications administered by a Professional Provider. The level of benefits You receive under this Program will be affected by a Prescription Drug's Generic/Brand status on the Formulary.

   To access the Formulary, visit our website at www.bcbsks.com or call Customer Service at the telephone number listed on Your Identification Card.
6. **Generic** means a Prescription Drug that: a) is equivalent to a Brand Drug, b) is available after the patent on that Brand Drug has expired and c) is available from more than one source. Equivalent means therapeutic equivalent as determined by the U.S. Food and Drug Administration.
7. **Mail Order Pharmacy** means an establishment that is registered or licensed in the state in which it is domiciled, from which Prescription Drugs are dispensed by a Pharmacist, which has entered into a written agreement to provide Prescription Drugs to Insureds of Blue Cross and Blue Shield of Kansas who are eligible under this Program, and which has been separately identified to Insureds in a directory or through some other means. The Mail Order Pharmacy, after receiving and processing Your Prescription Order, will deliver the Prescription Drugs through a parcel delivery service company.
8. **Pharmacist** means a person registered or licensed under his or her State's laws to dispense Prescription Drugs.
9. **Pharmacy Benefit Manager (PBM)** means an entity with which Blue Cross and Blue Shield of Kansas contracts for the provision of administrative, utilization review and network services for the covered drug and supplies under this Program.
10. **Prescription Drug** means a drug approved for general use in the United States by the U.S. Food and Drug Administration, assigned a National Drug Code (NDC) number and dispensed in compliance with federal or state laws pursuant to a Prescription Order or refill.
11. **Prescription Order** means the request Your Doctor may legally issue for a Prescription Drug.
12. **Prior Authorization** is the process of obtaining approval for certain Prescription Drugs based on criteria established by the Company. Prior Authorization is required for some Prescription Drugs covered under this Program. Prescription Drugs requiring Prior Authorization are listed on the Formulary. Prescription Drugs may be added or deleted from the list on a quarterly basis.
13. **Utilization Review** means a claims review process of medical necessity. It includes the review of the medical need for prescription and quantity prescribed and the Prescription Orders to verify that Prescription Drugs were dispensed as ordered.

C. Amount of Benefits

The Copayment amounts are:

Generic Prescription Drug $37.50

Brand Formulary Prescription Drug $75.00

Brand Non-Formulary Prescription Drug $112.50

Compound Prescription Drug $112.50

Annual Out-of-Pocket Maximum: The Annual Out-of-Pocket Maximum in the Comprehensive Program section is applicable to Prescription Drug benefits. Out-of-Pocket expenses include the Deductible, Coinsurance and/or Copayment provisions under the Comprehensive Program, Prescription Drug Program and Mail Order Pharmacy Program.

D. Covered Services

Except as limited, Prescription Drugs are covered when ordered by Your Doctor for a condition You have consulted Your Doctor about, dispensed by the Mail Order Pharmacy based on a Prescription Order, and Medically Necessary.

1. The covered Prescription Drug services include:
   a. The filling of the initial Prescription Order.
   b. Refills of the Prescription Order as authorized by Your Doctor within one year from the date of the initial Prescription Order but not before at least two thirds (2/3) of the previously purchased supply has been exhausted. Authorization for an early refill to accommodate a vacation supply may be obtained by contacting the Company, but not more often than two times per Insured during any 12-month period.
   c. The reissue of a Prescription Order by Your Doctor for a medication previously ordered, but not before at least two-thirds (2/3) of the previously purchased supply has been exhausted. Authorization for an early reissue to accommodate a vacation supply may be obtained by contacting the Company, but not more often than two times per Insured during any 12-month period.
   d. **Limitations:**
      (1) The benefit for Prescription Drugs pursuant to a Prescription Order filled through the Mail Order Pharmacy shall be limited to a supply sufficient for 90 consecutive days of therapy based on criteria established by the Company.
      (2) Prior Authorization is required for some Prescription Drugs covered under this Program.
      (3) A Pharmacy is not required to fill a Prescription Order which in the Pharmacist's judgment should not be filled.
      (4) Some excluded Prescription Drugs are listed on the Formulary. These exclusions are in addition to drugs or classes of drugs excluded under other provisions of this Certificate.
2. Growth hormone therapy is covered only under one of the following circumstances:

   If under age 18 and diagnosed with:

   a. Both laboratory proven growth hormone deficiency or insufficiency and significant growth retardation; or
   b. Substantiated Turner's Syndrome, Prader-Willi Syndrome, or Noonan's Syndrome with significant growth retardation; or
   c. Chronic renal insufficiency and end stage renal disease with significant growth retardation prior to successful transplantation; or
   d. Panhypopituitarism; or
   e. Neonatal hypoglycemia related to growth hormone deficiency.

   If age 18 and over with:

   a. Evidence of pituitary or hypothalamic disease or injury and laboratory proven growth hormone deficiency; or
   b. A history of prior growth hormone therapy for growth hormone deficiency or insufficiency in childhood and laboratory confirmation of continued growth hormone deficiency.

   Children, Adolescents and Adults:

   a. AIDS wasting syndrome
   b. Short bowel syndrome
   c. Severe burn patients

3. Diabetic Supplies and Insulin
4. Oral Anticancer Medication used to kill or slow the growth of cancerous cells. Such medication is covered at 100 percent of the allowable charge.
5. Psychotherapeutic drugs used for the treatment of Mental Illness and Substance Use Disorders under terms and conditions not less favorable than coverage provided for other Prescription Drugs.
6. Generic oral contraceptives will be covered at 100%.
7. Off-label Prescription Drugs used for the treatment of cancer.

E. Payment of Benefits

Subject to the Copayment above, Your benefits are based on the following allowable charges:

Mail Order Pharmacy -- The allowable charge for a covered Prescription Drug is as provided for in the Mail Order Pharmacy Agreement.

F. Exclusions

Benefits are not provided for:

1. Prescription Drugs for which normally (in professional practice) there is no charge.
2. Prescription Drugs for other than human use.
3. Orthopedic or prosthetic appliances and devices.
4. Contraceptive devices; therapeutic devices; artificial appliances; hypodermic needles; syringes or similar devices. This exclusion applies regardless of the intended use.
5. Prescription Drugs purchased from other than the Mail Order Pharmacy which is contracting with the Company to provide Prescription Drugs to Insureds under this program. This exclusion applies only to benefits under the Mail Order Prescription Drug Program. Claims for Prescription Drugs obtained via mail order from a pharmacy other than a contracting Mail Order Pharmacy shall be subject to the benefits of the Prescription Drug Program.
6. Charges for delivering any drugs.
7. A drug approved for experimental use.
8. Any drug prescribed or dispensed in a manner that does not agree with generally accepted medical or pharmaceutical practices.
9. Drugs, supplies, and equipment used in intravenous treatment.
10. Benefits are not available to the extent a Prescription Drug has been covered under another contract, certificate, or rider issued by Blue Cross and Blue Shield of Kansas.
11. Allergy antigens.
12. Any food item including breast milk, formulas and other nutritional products.
13. Total parenteral nutrition.
14. Drugs available over-the-counter in the equivalent dose which do not require a Prescription Order by federal or state law except those covered under the Preventive Health Benefits section.
15. Charges for services that are not listed as covered services.
16. Services for injuries or diseases related to Your employment to the extent You are covered or are required to be covered by a worker's compensation law. If You enter into a settlement giving up Your right to recover past or future medical benefits under a worker's compensation law, the Company will not pay past or future medical benefits that are the subject of or related to that settlement.

    In addition, if You are covered by a worker's compensation program which limits benefits when other than specified providers are used, and You receive services from a provider not specified by the program, the Company will not pay balances of charges from such non-specified providers after Your benefits under the program are exhausted.
17. Services in which duplicate benefits are available under federal, state, local laws, regulations or programs. Examples of such programs are: Medicare; TRICARE; services in any veteran's facility when the services are eligible for coverage by the government. This Mail Order Prescription Drug Program will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid.

This exclusion applies whether or not You choose to waive Your rights to these services except for those services that would be eligible for benefits under Medicare Part D prescription drug coverage. Such benefits shall only be excluded if You are enrolled in Part D.

18. Any service provided through a district pursuant to an Individual Education Plan (IEP) as required under any federal or state law. This exclusion applies whether or not You choose to waive Your rights to these services.
19. Health services associated with accidental bodily injuries arising from a motor vehicle accident to the extent such services are payable under medical expense payment provision of any automobile insurance policy.
20. Services not prescribed by a Doctor or continued after a Doctor has advised that further care is not necessary.
21. Services that are not Medically Necessary, as defined in this Mail Order Prescription Drug Program.
22. Prescription Drugs utilized primarily for stimulation of hair growth. This exclusion applies even if the drug is prescribed for purposes other than the stimulation of hair growth.
23. Charges for completion of insurance claim forms.
24. Any drug, device or medical treatment or procedure and related services that are, as of the date of service, Experimental or Investigational as defined in the General Definitions section. This exclusion does not apply to routine patient care services (as defined in Kansas Administrative Regulation 40-4-43) provided in an approved cancer clinical trial for which benefits would otherwise be available for the same services when not provided in connection with such clinical trial.
25. Services provided directly for or relative to diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion, or aggression.
26. Any drug or supply associated with the medical management and treatment of obesity. This includes, but is not limited to, nutrients and Prescription Drugs prescribed for purposes other than the treatment of obesity.
27. Appetite suppressants.
28. Any service or supply provided or obtained relative to an excluded service. "Provided relative to" refers to any service or supply which would not have been provided or obtained if the excluded service would not have been provided and which is provided on either an Inpatient or Outpatient basis by any Eligible Provider.
29. Growth hormone therapy or other drugs used to treat growth failure except in those situations specifically set out as eligible for benefits.
30. Certain Prescription Drugs that have therapeutically equivalent or interchangeable drugs that are available over the counter (OTC) and may be obtained without a Prescription Order. This would include drug products from the same therapeutic class containing different chemical entities, but which would provide similar effects or the same pharmacological action when administered in therapeutically equivalent doses. These drugs are listed on the Formulary.
31. Prescription Drugs listed as excluded on the Formulary. Such exclusions are in addition to drugs or classes of drugs excluded under other provisions of this Certificate.
32. Specialty Prescription Drugs.

ALLOWABLE CHARGES

This Section will tell You what the allowable charge for a service is. It may or may not be the same as the actual charge. Inclusion of a service or provider type in the Allowable Charges section below does not imply coverage for such service. See Covered Services to determine the extent of Your coverage.

As used herein, actual charge means the total amount billed by a provider to all parties for a particular service.

A. Contracting Providers of Blue Cross and Blue Shield of Kansas for other than Prescription Drugs or Sleep Studies.

The Contracting Provider Agreement between the provider and the Company sets out the method the Company will use to determine allowable charges for covered services. Contracting Providers have agreed to accept the Company's determination of Your benefits as payment in full for covered services, except that You are responsible for payment of: Deductible, Coinsurance, Copayment/Copay amounts, shared payment amounts, non-covered services, private room charges in excess of the allowable amount stated in Your Certificate, and amounts in excess of any other benefit limitations of Your Certificate.

B. Contracting Providers of Blue Cross and Blue Shield of Kansas for limited services for other than Prescription Drugs or Sleep Studies.

In certain situations, Institutional Providers may be Contracting Providers for only a limited set of services, e.g., chemical dependency treatment or Outpatient treatment of Medical Emergencies and Accidental Injuries. In such cases, such an Institutional Provider will be treated as a Contracting Provider for the purpose of acceptance of allowable charges established by the Company as payment in full, and direct payment of benefits. For services other than the limited set of services identified above, these Institutional Providers will be considered Non-Contracting.

C. Prescription Drugs

The allowable charge is the amount that contracting providers of the Company's Pharmacy Benefit Manager have agreed to as payment in full for covered Prescription Drugs and/or supplies except that You are responsible for payment of any Deductible, Coinsurance or Copayment/Copay amounts.

D. Contracting Providers of Sleep Studies.

1. **Sleep Studies provided within the Company Service Area:**

   a. **Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of Blue Cross and Blue Shield of Kansas that are Accredited by the American Academy of Sleep Medicine (AASM) and/or the Accreditation Commission for Health Care, Inc. (ACHC) and the physicians to be board certified in sleep medicine.**

   The Contracting Provider Agreement between the provider and the Company sets out the method the Company will use to determine allowable charges for covered services. Contracting Providers have agreed to accept the Company's determination of Your benefits as payment in full for covered services, except that You are responsible for payment of: Deductible, Coinsurance, Copayment/Copay amounts, shared payment amounts, non-covered services, private room charges in excess of the allowable amount stated in Your Certificate, and amounts in excess of any other benefit limitations of Your Certificate.

   b. **Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of Blue Cross and Blue Shield of Kansas that are Not Accredited by the American Academy of Sleep Medicine (AASM) and/or the Accreditation Commission for Health Care, Inc. (ACHC) and the physicians to be board certified in sleep medicine.**

   The allowable charge will be the actual charge for covered services up to 60% of the maximum amount allowable to a Contracting Provider that is accredited by the American Academy of Sleep Medicine or Board Certified in Sleep Medicine. Contracting Providers have agreed to accept the Company's determination of Your benefits as payment in full for covered services, except that You are responsible for payment of: Deductible, Coinsurance, Copayment/Copay amounts, shared payment amounts, non-covered services, private room charges in excess of the allowable amount stated in Your Certificate, and amounts in excess of any other benefit limitations of Your Certificate.

2. **Sleep Studies provided outside the Company Service Area:**

   a. **Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Accredited by the American Academy of Sleep Medicine (AASM) and/or the Accreditation Commission for Health Care, Inc. (ACHC) and the physicians to be board certified in sleep medicine.**

   The allowable charge will be the actual charge up to the maximum amount allowable as determined as described in item F.2.a. below.

b. **Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Not Accredited by the American Academy of Sleep Medicine (AASM) and/or the Accreditation Commission for Health Care, Inc. (ACHC) and the physicians to be board certified in sleep medicine.**

The allowable charge will be the actual charge for covered services up to 60% of the maximum amount allowable as determined in F.2.a. below. You will be responsible for the difference between the allowable charge and the maximum amount allowable as determined in item D.2.a. above.

E. Non-Contracting Providers

If You receive services from a provider who has not contracted with Blue Cross and Blue Shield of Kansas or another Blue Cross and Blue Shield Company (for services provided outside the Company Service Area), the allowable charges (before application of any Deductible, Coinsurance, Copayment/Copay, shared payment or benefit limits called for by Your Certificate) will be determined as follows and You are responsible for any difference between the allowable charge and the actual charge. As used in this section, "Contracting" means contracting with Blue Cross and Blue Shield of Kansas.

When a covered service that is required for a Medical Emergency is provided by a Non-Contracting Provider, the allowable charge will be the actual charge for the service up to the maximum amount allowable for the same service provided by providers that are Contracting Institutional Providers of the Company that are the same kinds of providers or Contracting Professional Providers of the Company with the same licensure or certification.

"Same service" as used in this Section E shall be determined on the basis of the intended result of the service and not the technical methodology used by the provider to perform that service.

All reimbursement identified in this Section E is paid according to the cost-containment policies and procedures applicable to Contracting Providers. If You receive services from a Non-Contracting Provider, You will be responsible for payment for services for which payment is not made by the Company due to a cost-containment policy or procedure applicable to a Contracting Provider of the same licensure providing the same service. Such cost-containment policies include, but are not limited to, determinations by the Company that the services provided are of such a nature that they should be considered one service with a single payment, or that the billing for service inappropriately categorized the nature of the services performed, in the opinion of the Company, and payment should be made for a different type or different intensity of service.

1. **General Acute Care and Special Hospitals**

a. **Inpatient Services**

(1) **General Acute Care (Full-Service) Hospitals** -- The allowable charge for Inpatient services will be the lesser of:

(a) the actual charge; or

(b) 80% of the prior calendar year's average allowed charge per day (sum of allowed charges divided by sum of Inpatient days) for Contracting facilities in the same Peer Group (as designated below); or

(c) 80% of the prior calendar year's average allowed charge per day for all Contracting General Acute Care Hospitals in Kansas.

For purposes of this provision, "General Acute Care Hospitals" are defined as those Hospitals providing 24-hour emergency care, as well as a wide range of other medical services.

For purposes of this provision, "Peer Group Designations" are as follows:

Peer Group Designations

1 = Hospitals with less than 50 beds

2 = Hospitals with 51-99 beds

3 = Hospitals with more than 100 beds (excluding Topeka and Wichita)

4 = Topeka Hospitals

5 = Wichita Hospitals

(2) **Special Hospitals --** The allowable charge for Inpatient services will be the lesser of:

(a) the actual charge; or

(b) 80% of the prior calendar year's average allowed charge per day (sum of allowed charges divided by sum of Inpatient days) for all Contracting Special Hospitals of the Company.

For purposes of this provision, "Special Hospitals" are defined as those Hospitals which are primarily or exclusively engaged in the care and treatment of patients with specified medical conditions, including cardiac, orthopedic, or surgical patients.

b. **Outpatient Services** -- The Outpatient services allowable charge will be the lesser of:

(1) the actual charge; or

(2) 80% of the current year's lowest maximum amount allowable used for all Contracting Institutional Providers.

If a maximum amount allowable has not been set for services provided on an Outpatient basis, the allowable charge will be 80% of the actual charge. If no Contracting Provider provides the same service, the Company will determine an amount to be allowed for the procedure at its discretion.

2. **All Other Hospitals and Ambulatory Surgical Centers**

The allowable charge will be the lesser of:

a. the actual charge; or

b. 80% of the maximum amount allowable for a Contracting Provider for the same service.

If no Contracting Provider provides the same service, the Company will determine an amount to be allowed for the procedure at its discretion.

3. **Medical Care Facilities --** The allowable charge is the actual charge for covered services up to 80% of the maximum amount allowable for a Medical Care Facility that is a Contracting Provider.

4. **Ambulance Service --** The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable for the ambulance service had it been provided by a Contracting Provider of ambulance service under similar circumstances.

5. **Doctors of Medicine, Doctors of Osteopathy, Dentists, Optometrist, Chiropractors, Podiatrists or Certified Psychologists --** The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable for the same procedure by providers that are Contracting Providers of the Company with the same licensure or certification. If no Contracting Providers provide the same service, the Company will determine an amount to be allowed for the procedure.

6. **Private Duty Nursing, Home Health Care, Hospice, Medical Supplies, Orthopedic Appliances, Prostheses, and Other Services that may be covered by Your Certificate --** The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable for the same service by providers that are Contracting Providers of the Company with the same licensure or certification.

7. **Sleep Studies**

a. **Sleep Studies provided within the Company Service Area:**

1. **Non-Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of Blue Cross and Blue Shield of Kansas that are Accredited by the American Academy of Sleep Medicine (AASM) or Non-Contracting Professional Providers of Blue Cross and Blue Shield of Kansas that are Board Certified in Sleep Medicine**

The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable as determined in item D.1.a. above.

2. **Non-Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of Blue Cross and Blue Shield of Kansas that are Not Accredited by the American Academy of Sleep Medicine (AASM) or Non-Contracting Professional Providers of Blue Cross and Blue Shield of Kansas that are Not Board Certified in Sleep Medicine**

The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable as determined in item D.1.b. above.

b. **Sleep Studies provided outside the Company Service Area:**

1. **Non-Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Accredited by the American Academy of Sleep Medicine (AASM) or Non-Contracting Professional Providers of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Board Certified in Sleep Medicine**

The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable as determined in item D.2.a. above.

2. **Non-Contracting Institutional Providers or Freestanding Sleep Centers/Laboratories of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Not Accredited by the American Academy of Sleep Medicine (AASM) or Non-Contracting Professional Providers of the Blue Cross and Blue Shield Company servicing the area in which the service is provided that are Not Board Certified in Sleep Medicine**

   The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable as determined in item D.2.b. above.

8. **Dentists**

   a. **Dental Services provided within the Company Service Area:**

   The allowable charge will be the actual charge for covered services up to 80% of the maximum amount allowable for the same procedure by dentists that are Contracting Providers of the Company with the same licensure or certification. If no Contracting Providers provide the same service, the Company will determine an amount to be allowed for the procedure in its discretion.

   b. **Dental Services provided outside the Company Service Area:**

   The allowable charge is the smaller of: the actual charge for the service or the maximum allowable charge for the service as determined by the Company.

F. Out-of-Area Services

1. **In areas where the Company offers contracting provider status directly or through arrangements to a class or classes of providers (such as Hospitals and/or physicians):**

   a. When a provider in such class contracts with the Company, the provisions in Section A apply.

   b. When a provider in such class does not contract with the Company, the provisions in Section E apply.

2. **For out-of-area arrangements other than those set forth in item F. 1:**

   Blue Cross and Blue Shield of Kansas has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever You obtain healthcare services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees.

   Typically, when accessing care outside our service area, You will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, You may obtain care from non-participating healthcare providers. Our payment practices in both instances are described or referenced below.

   a. **BlueCard Program (not applicable to Sleep Studies and Dental Services not associated with Accidental Injuries)**

   Under the BlueCard Program, when You access covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

   Whenever You access covered healthcare services outside our service area and the claim is processed through the BlueCard Program, the amount You pay for covered healthcare services is calculated based on the lower of:

   - The billed covered charges for Your covered services; or
   - The negotiated price that the Host Blue makes available to us.

   Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with Your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

   Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for Your claim because they will not be applied retroactively to claims already paid.

   Federal law or laws of a small number of states may require the Host Blue to add a surcharge to Your calculation. If any federal law or the state laws mandate other liability calculation methods, including a

surcharge, we would then calculate Your liability for any covered healthcare services according to applicable law.

If You receive covered healthcare services under a Value-Based Program inside a Host Blue's service area, You will not bear any portion of provider incentives, risk sharing, and/or care coordination fees of such arrangement, except when a Host Blue passes those fees to us through average pricing, or fee schedule incentive adjustments. Value-Based Program means an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality factors and is reflected in provider payment.

b. **Non-Participating Healthcare Providers Outside the Blue Cross and Blue Shield of Kansas Service Area - See Section E, Non-Contracting Providers, above.**

GENERAL EXCLUSIONS

The following General Exclusions apply to all Your coverages described in this Certificate. Additional limitations and exclusions that apply to specific benefits may be found within the description of such benefits.

A. Benefits will not be provided for:

1. Services that are not listed as covered services.
2. Services for injuries or diseases related to Your employment to the extent You are covered or are required to be covered by a worker's compensation law. If You enter into a settlement giving up Your right to recover past or future medical benefits under a worker's compensation law, the Company will not pay past or future medical benefits that are the subject of or related to that settlement.

   In addition, if You are covered by a worker's compensation program which limits benefits when other than specified providers are used, and You receive services from a non-specified provider not specified by the program, the Company will not pay balances of charges from such non-specified providers after Your benefits under the program are exhausted.
3. Services in which duplicate benefits are available under federal, state, or local laws, regulations or programs. Examples of such programs are: Medicare; TRICARE; services in any veteran's facility when the services are eligible for coverage by the government. This Certificate will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid.

   This exclusion applies whether or not You choose to waive Your rights to these services except for those services that would be eligible for benefits under Medicare Part D prescription drug coverage. Such benefits shall only be excluded if You are enrolled in Part D. Waiving Your rights to these services shall include failure to purchase coverage under any such government programs, including Medicare Parts A and B, when You are eligible to purchase such coverage.
4. Any service provided through a school district pursuant to an Individual Education Plan (IEP) as required under any federal or state law.

   This exclusion applies whether or not You choose to waive Your rights to these services.
5. Services not prescribed by a Doctor or continued after a Doctor has advised that further care is not necessary.
6. Services that are not Medically Necessary, as defined in the Certificate.
7. Services that are determined not to be medically necessary through the hospital's Utilization Review process. In the absence of a hospital Utilization Review process, the Company has the right to determine when services are medically unnecessary.
8. Services provided by Institutional and Professional Providers for unnecessary Inpatient admissions when services and evaluations that could satisfactorily be provided on an Outpatient basis.
9. Any drug, device or medical treatment or procedure and related services that are, as of the date of service, Experimental or Investigational as defined in the General Definitions section. This exclusion does not apply to routine patient care services (as defined in Kansas Administrative Regulation 40-4-43) provided in an approved cancer clinical trial for which benefits would otherwise be available for the same services when not provided in connection with such clinical trial.
10. Procedures and diagnostic tests that are considered to be obsolete by the Company's professional medical-advisory committee.
11. Services provided directly for or relative to diseases or injuries caused by or arising out of acts of war, insurrection, rebellion, armed invasion, or aggression.
12. Services that are already covered under another provision of this Certificate.
13. Blood or payment to blood donors.
14. Any service or supply associated with the medical management and treatment of obesity. This includes but is not limited to surgery, office visits, hospitalizations, laboratory or radiology services, prescription drugs, medical weight reduction programs, nutrients and diet counseling except for those services covered as Preventive Health Benefits.
15. Inpatient Skilled Care, Intermediate Care, Convalescent Care, Custodial/Maintenance Care or Rest Cures.
16. All services associated with transplant procedures except those specifically set out as benefits.

17. Services associated with any mass screening type of physical or health examination except for pap smears and mammograms performed at a mobile facility certified by the Centers for Medicare and Medicaid Services. Two examples of mass screenings are mobile vans and school testing programs.
18. Autogenic biofeedback services and materials except for urinary incontinence in adults 18 years old and older.
19. Acupuncture.
20. Services or supplies associated with sex changes/gender reassignment, and services related to sexual function, and any related complications.
21. Reversal of sterilization procedures.
22. In vitro fertilization, in vivo fertilization or any other medically-aided insemination procedure.
23. Charges for autopsies, unless the autopsy is requested by Blue Cross and Blue Shield of Kansas.
24. Transportation other than covered Ambulance Services.
25. Charges for completion of insurance claim forms.
26. Laboratory services performed by an independent laboratory that is not approved by Medicare.
27. Prescription drugs utilized primarily for stimulation of hair growth. This exclusion applies even if the drug is prescribed for purposes other than the stimulation of hair growth.
28. Cosmetic or reconstructive surgery except when the surgical procedure is one of the following:
    a. Cosmetic or reconstructive repair of an Accidental Injury.
    b. Reconstructive breast surgery in connection with a Medically Necessary mastectomy that resulted from a medical illness or injury. This includes reconstructive surgery on a breast on which a mastectomy was not performed in order to produce a symmetrical appearance.
    c. Repair of congenital abnormalities and hereditary complications or conditions, limited to:
        (1) Cleft lip or palate.
        (2) Birthmarks on head or neck.
        (3) Webbed fingers or toes.
        (4) Supernumerary fingers or toes.
    d. Reconstructive services performed on structures of the body to improve/restore impairments of bodily function resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

    For purposes of this provision, the term "cosmetic" means procedures and related services performed to reshape structures of the body in order to alter the individual's appearance.
29. Refractive procedures including; radial keratotomies, corneal relaxation, keratophakia, keratomileusis, or any other procedure used to reshape the corneal curvature except for Medically Necessary procedures associated with severe anisometropia.
30. All services associated with Temporomandibular Joint Dysfunction Syndrome except those services specifically set out as benefits.
31. Health services associated with accidental bodily injuries arising from a motor vehicle accident to the extent such services are payable under a medical expense payment provision of any automobile insurance policy. The excluded expenses cannot be used for any purpose under this Certificate.
32. Automatic external defibrillators.
33. Institutional Provider services for personal items such as television, radio, telephone, comfort kits, materials used in occupational therapy, air conditioning provided on an optional basis, or internet access.
34. Professional Provider services or charges for:
    a. Services where the Provider would normally make no charge.
    b. Travel expenses, mileage, time spent traveling, telephone calls, charges for services provided over the telephone, services provided through e-mail or electronic communications. For the purpose of this provision electronic communications means communication other than telemedicine. Telemedicine means the use of telecommunications technology to provide, enhance, or expedite health care services, as by accessing off-site databases, linking clinics or physicians' offices to central hospitals, or transmitting x-rays or other diagnostic images for examination at another site.

c. Services by an immediate relative or member of Your household. "Immediate relative" means the husband or wife, children, parents, brother, sister, or legal guardian of the person who received the service. "Member of Your household" means anyone who lives in the same household and who was claimed by You as a tax deduction for the year during which the service was provided.

d. Repair or replacement of dental plates and all dental care other than that listed as a covered service.

e. Hearing aids; servicing of visual corrective devices, or consultations related to such services; orthoptic and visual training.

35. Any service associated with dental implants, surgical treatment or diagnostic services except as otherwise stated in this Certificate.

36. Educational benefits except for those pertaining to diabetic education, colostomy care, wound care, IV therapy, or any other condition or treatment which the Company has determined is appropriate for home care education.

37. Dental appliances or restorations necessary to increase vertical dimensions or restore the occlusion.

38. Any food item including breast milk, formulas and other nutritional products.

39. Appetite suppressants.

40. Drugs which are available in an equivalent dose over-the-counter and which do not require a Prescription Order by federal or state law.

41. Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders IV(1994) which are not attributable to a mental disorder and are a focus of clinical attention, e.g., marriage counseling. This exclusion applies to all benefits provided by this Certificate; it is not limited to those benefits listed for Mental Illness or Substance Use Disorders.

42. Any service or supply provided or obtained relative to an excluded service. "Provided relative to" refers to any service or supply which would not have been provided or obtained if the excluded service would not have been provided and which is provided on either an Inpatient or Outpatient basis by any Eligible Provider.

43. Diagnostic tests and evaluations are ordered, requested or performed solely for the purpose of resolving issues in the context of legal proceedings, including those concerning custody, visitation, termination of parental rights, civil damages or criminal actions.

44. Services, appliances or restorations for altering vertical dimension for restoring occlusion, for replacing tooth structure lost by attrition or abrasion, bruxism, erosion or abfractions; for aesthetic purposes; splinting or equilibration.

45. Temporary or Provisional dental services and procedures, including, but not limited to, Provisional crowns, Provisional splinting, interim complete or partial dentures. "Provisional" means a service or procedure that is provided for temporary purposes or is used over a limited period; a temporary or interim solution; usually refers to a prosthesis or individual tooth restoration.

46. Dental services and prosthodontic devices that are duplicated in whole or in part, due to the Insured failing to complete the initial treatment plan.

47. Pharmacological agent(s) inserted into a periodontal pocket to suppress pathogenic microbiota.

48. Any device used for enhancing or enabling communication except for an electrolarynx.

49. Services provided for a Mental Illness or Substance Use Disorder by a provider that is not an Eligible Provider for Mental Illness or Substance Use Disorders.

50. Non medical services (including but not limited to legal services, social rehabilitation, educational services, vocational rehabilitation, job placement services).

51. Services of volunteers.

52. Any assessment to attend an alcohol and drug safety action program by a diversion agreement or by court order.

53. Prostheses that require surgical insertion into the body and are billed by an entity or person that is not the Hospital or Ambulatory Surgical Center where the surgery was performed.

54. Services for or related to elective abortions.

For purposes of this provision, "elective" means as follows: for any reason other than to prevent the death of the mother upon whom such services are performed, except that it includes those services based on a claim or diagnosis that the mother shall or may engage in conduct likely to result in her death.

For the purpose of this provision, "abortion" means as follows: the use or prescription of any instrument, medicine, drug, or any other substance or device to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of a child after live birth, or to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma, or physical assault on the pregnant woman or her unborn child and which causes the premature termination of the pregnancy.

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APPEAL PROCEDURES

A. Purpose. This section outlines the procedures for and the time periods applicable to Claim and Appeal determination decisions for Adverse Decisions. It is the policy of the Company to afford Insureds a full and fair review of Claim decisions and Appeal decisions as a right under applicable federal and state law.

However, an Insured's rights accrued hereunder or under applicable state or federal law (including but not limited to ERISA) are not assignable to any person or entity. Authorized Representatives may be designated as provided in Section B below.

B. Definitions. For the purpose of this Appeal Procedures Section, the following terms and their definitions apply:

1. **Adverse Decision,** for the purposes of these Appeals procedures (and ERISA, as applicable), means a denial in whole or in part of a Pre-Service Claim or a Post-Service Claim and for which You are financially responsible or, for a Pre-Service Claim, for which You would be financially responsible, if You obtained the service. Adverse Decision, for the purposes of External Review procedures, is limited to the definition of Adverse Decision Eligible for External Review. Adverse Decision also means any retroactive cancellation of coverage other than for non-payment of premium.
2. **Adverse Decision Eligible for External Review** means (1) in the case of other than an Emergency Medical Condition, a Claim for a proposed or delivered health care service which would otherwise be covered under this Certificate but for which the Insured has received an Adverse Decision following an Appeal due to the fact that the service is not or was not Medically Necessary or the health care treatment has been determined by the Company to be Experimental or Investigational and the denial leaves the Insured with a financial obligation or prevents the Insured from receiving the requested service, or (2) in the case of an Emergency Medical Condition, a Claim for which an initial Adverse Decision by the Company that a proposed health care service which would otherwise be covered under this Certificate is not Medically Necessary or the health care treatment has been determined by the Company to be Experimental or Investigational and the denial would leave the Insured with a financial obligation or prevents the Insured from receiving the requested service, or (3) a Pre-Service Request for a benefit determination or advance approval a) that is not a Pre-Service Claim; b) which is denied by the Company due to the fact the requested services are not Medically Necessary or are Experimental or Investigational; and c) based upon which You choose not to obtain the requested services. For item (3) above, no Appeals need be submitted to the Company in order for the Adverse Decision to be eligible for External Review. For items (1) and (2) above, the procedure in section D. below applies. Notwithstanding any provision of this Certificate to the contrary, the External Review procedure is not available for dental services.
3. **Appeal** means a written request, except in the case of Urgent Care in which case the request may be submitted orally or in writing, for review of an Adverse Decision that is submitted to the Company by an Insured or the Insured's Authorized Representative.
4. **Authorized Representative** means, for non-urgent care, a person designated by You in writing as authorized to represent them for Appeals as permitted under ERISA. This may only be achieved through use of a form provided by BCBSKS by contacting the Customer Service Center at the telephone number on the back of Your identification card. Any attempt to designate via any other form shall be deemed void and ineffective on its face. For Urgent Care, such written authorization is not required if the Appeal is made on Your behalf by a health care provider with knowledge of Your medical condition.
5. **Claim for Benefits or Claim** means a request for treatment benefit or payment benefits made by an Insured in accordance with the Company's procedure for filing Claims. A Claim includes both Pre-Service Claims and Post-Service Claims. A Claim must have sufficient information upon which to base a decision regarding benefits according to all of the provisions of the Certificate.
6. **Emergency Medical Condition** means:
   a. The sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part or would place a person's health in serious jeopardy;
   b. a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the Insured or would jeopardize the Insured's ability to regain maximum function; or
   c. a medical condition for which coverage has been denied based on a determination that the recommended or requested health care service or treatment is experimental or investigational, if the Insured's treating physician certifies, in writing, that the recommended or requested health care service or treatment for the medical condition would be significantly less effective if not promptly initiated.
7. **ERISA** means the Employee Retirement Income Security Act of 1974. ERISA is a federal law that applies to employer sponsored health benefit plans if the employer is not a government entity or a church organization.

8. **External Review** means the review of an Adverse Decision by an External Review Organization.
9. **External Review Organization** means an entity that conducts independent External Reviews of Adverse Decisions pursuant to a contract with the Kansas Insurance Department.
10. **Pre-Service Claim** means a request for a Claims decision when prior authorization of the services is required by the Company.
11. **Pre-Service Request** means a request for advance information on the Company's possible coverage of items or services or advance approval of covered items or services that do not constitute Pre-Service Claims. Subsequent inquiries regarding the same service or item shall not be considered a Pre-Service Request unless additional substantive clinical information is provided.
12. **Post-Service Claim** means a request for a Claims decision for services that have been provided.
13. **Urgent Care** means care for a condition that delay in receiving such care could seriously jeopardize the life or health of the Insured or the ability of the Insured to regain maximum function or, in the opinion of a physician knowledgeable of the Insured's condition, would subject the Insured to severe pain that could not be adequately managed without care or treatment. In determining whether a Claim involves Urgent Care, the Company must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a physician with knowledge of the Insured's medical condition determines that a Claim involves Urgent Care, the claim must be treated as an Urgent Care Claim.

C. Initial Claim Decisions

The time periods in which the Company must make initial Claim decisions (the first determination of benefits available for an Urgent Care Claim, a Pre-Service Claim or a Post-Service Claim) are as follows:

Action	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Initial Benefit Decision (from the date the Claim is received by the Company)	72 hours	15 days	30 days
Extension (from the date the Claim is received by the Company)	None - Notice requesting additional information due - 24 hours*	30 days*	45 days*

* The time periods listed are those required. An Insured may voluntarily agree to provide the Company additional time within which to make a decision.

Time for Insured to Provide more Information (from the date the information was requested by the Company)	48 hours	45 days	45 days

D. Appeal of Initial Adverse Decisions (including Adverse Decisions Eligible for External Review)

An Insured or the Insured's Authorized Representative has the right to obtain, without charge, copies of documents relating to the Adverse Decision and has the right to appeal an Adverse Decision from an initial Claim decision. This is a first level Appeal.

1. The time periods that apply to first level Appeal decisions are as follows:

Action	Urgent Care Claim	Pre-Service Claim	Post-Service Claim Retroactive Cancellation
Time to File Appeal (from the date of receipt of the Adverse Decision)	180 days	180 days	180 days
Initial Appeal Decision (from the date the Appeal is received by the Company)	72 hours	15 days	30 days
Extension	None*	None*	None*

(from the date the Appeal is received by the Company)

* The time periods listed are those required. An Insured may voluntarily agree to provide the Company additional time within which to make a decision.

2. A first level Appeal will be coordinated by a representative of the Company's Customer Service Center.

E. Procedure for Pursuing an External Review

1. The Insured has the right to request an External Review of an Adverse Decision Eligible for External Review after an Appeal (where applicable) has been completed or when the Insured has not received a final Adverse Decision within 60 days of seeking such review, unless the delay was requested by the Insured. In the case of a request for an External Review of an Adverse Decision Eligible for External Review involving an Emergency Medical Condition, such request may be made before the Insured has exhausted all the other available review procedures. The Company will notify the Insured in writing regarding a final Adverse Decision and of the opportunity to request an External Review.

2. Within four (4) months of receipt of the notice of a final Adverse Decision, the Insured, the treating physician or health care provider acting on behalf of the Insured with written authorization from the Insured, or a legally authorized designee of the Insured must make a written request for an External Review to the Kansas Insurance Commissioner, at the Kansas Insurance Department, 420 SW 9th Street, Topeka, KS 66612, (785) 296-3071 or (800) 432-2484.

3. Within ten (10) business days of receipt of such request (immediately, when the request for External Review involves an Emergency Medical Condition), the Kansas Insurance Commissioner will notify the Insured and other involved parties as to whether the request for External Review is granted.

4. For those requests that qualify for External Review, the External Review Organization will issue a written decision to the Insured and the Kansas Insurance Commissioner within 30 business days. The External Review Organization will issue its written decision within 72 hours when the request for External Review involves an Emergency Medical Condition. The standard of review shall be whether the health care service denied by the Company was Medically Necessary or in the case of reviews regarding Experimental or Investigational treatment, whether the health care service denied by the Company was covered or excluded from coverage under the terms of this Certificate.

5. The decision of the External Review Organization may be reviewed directly by the district court at the request of either the Insured, insurer, or health insurance plan. The review by the district court shall be de novo. The decision of the External Review Organization shall not preclude the Insured, insurer or health insurance plan from exercising other available remedies applicable under state or federal law. Seeking a review by the district court or any other available remedies exercised by the Insured, insurer or health insurance plan after the decision of the External Review Organization will not stay the External Review Organization's decision as to the payment or provision of services to be rendered during the pendency of the review by the insurer or health insurance plan. All material used in an External Review and the decision of the External Review Organization as a result of the External Review shall be deemed admissible in any subsequent litigation.

The right to External Review shall not be construed to change the terms of coverage under this Certificate. In no event shall more than one External Review be available during the same year for any request arising out of the same set of facts.

F. Right to a Judicial Review

You have the right to bring suit (including under ERISA Section 502(a) if applicable) in state or federal court (as appropriate) only after You have exhausted the first level Appeal of an Adverse Decision, whether or not You pursue External Review. However, in the case of an Adverse Decision Eligible for External Review involving an Emergency Medical Condition, no Appeal is necessary and only completion of the External Review process is required in order for the right to bring suit to accrue. In all events, such suit or proceeding must be commenced no later than 5 years after the date from the time written proof of loss is required to be given.

G. Strict Adherence by Company

If for any reason the Company fails to strictly adhere to these appeal procedures as required by state or federal law, the Insured shall be deemed to have exhausted the internal claims and appeals process regardless of whether the Company asserts it substantially complied with appeals procedures or committed any de minimis error.

GENERAL INFORMATION

A. Company's Right to Determine if Services are Medically Necessary: Benefits are available only for medically necessary services. The Company has the right to require information, including medical records, to make this decision.

B. Insured/Provider Relationship: The choice of a provider is solely that of the Insured.

C. The Company's Responsibility is Limited: Institutional Provider services are subject to the rules and regulations of the provider including rules about admissions, discharge and availability of services. The Company does not guarantee that admission or any specific type of room or kind of service will be available.

The Company is obligated to provide benefits for the services of Your Eligible Provider only to the extent provided in this Certificate. The Company does not guarantee the availability of a provider.

The Company shall not be liable for any acts or admissions of any provider of service. This includes negligence, misconduct, malpractice, refusal to provide a service or breach of contract.

D. Your Identification Card: When You receive services, show Your current Identification Card when obtaining services from an Eligible Provider at the provider's office.

E. Your Authorization: By accepting coverage under this Certificate, You permit the Company to request any information related to a claim for services that You received and authorize that any information may be given to the Company regarding medical services You have received. This applies to all types of claims, including claims related to Medicare.

If the Company asks for information and does not receive it, payment for covered services cannot be made. The claim will be processed for payment only when the requested information has been received and reviewed.

F. Notice of Claim: You are responsible for submitting written notice of claim within 20 days after a covered loss begins or as soon as reasonably possible. If Your provider submits written notice on Your behalf within the time period specified above, such notice will satisfy the requirements of this provision. The notice can be given to Blue Cross and Blue Shield of Kansas at its home office, 1133 SW Topeka Boulevard, Topeka, Kansas 66629. Notice should include Your name and Your identification number as stated on Your Identification Card.

G. Claim Forms: The Company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice the claimant shall be deemed to have complied with the claim filing requirements of Your Certificate.

H. Proof of Loss: Written proof of loss must be furnished to the Company at 1133 SW Topeka Boulevard, Topeka, Kansas 66629, in case of claim for loss for which Your Certificate provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the Company is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

I. Time of Payment of Claims: Benefits payable under Your Certificate will be paid immediately upon receipt of proper written proof of loss.

J. Payment of Claims. For covered services received from the following providers:

1. **Contracting Provider of Blue Cross and Blue Shield of Kansas or another entity on behalf of Blue Cross and Blue Shield of Kansas:** Your benefits will be paid directly to the Contracting Provider.
2. **Contracting Provider of Blue Cross and Blue Shield of Kansas for limited services:**

   When You receive services for which the provider is contracting Your benefits will be paid directly to the Contracting Provider.

   When You receive services for which the provider is not contracting Your benefits will be paid directly to You. Such benefits are personal to You and cannot be assigned to any other person or entity.
3. **Non-Contracting Provider in the Company Service Area:** Your benefits will be paid directly to You. Such benefits are personal to You and cannot be assigned to any other person or entity.
4. **Covered Provider in a class of providers that are not offered Contracting Provider status:**

   Your benefits will be paid directly to You, with such benefits being personal to You and not assignable to any other person or entity.
5. **Covered Provider Outside the Company Service Area:**

a. Located in an area where the Company offers contracting provider status, directly or through arrangements with another entity, to the provider from whom service was received:

(1) if the provider is a Contracting Provider, Your benefits will be paid to the provider.

(2) if the provider is a Non-Contracting Provider, Your benefits will be paid directly to You, with such benefits being personal to You and not assignable to any other person or entity.

b. Located in an area where the Company does not offer contracting provider status, either directly or through arrangements with another entity, to the provider from whom service was received:

(1) In instances where the Insured receives service from a provider that is contracting with the Blue Cross and/or Blue Shield Company servicing the area in which the provider is located, payment will be made directly to the provider.

(2) In instances where the Insured receives service from a provider that is not contracting with the Blue Cross and/or Blue Shield Company servicing the area in which the provider is located, Your benefits will be paid directly to You, with such benefits being personal to You and not assignable to any other person or entity.

6. Any benefits unpaid at Your death may be paid to Your estate.

If benefits are payable to Your estate, the Company may pay up to $1,000 to anyone related to You by blood or marriage, whom the Company considers to be entitled to the benefits. The Company will be discharged to the extent of any such payment made in good faith.

K. Physical Examination: The Company, at its expense, has the right to have You examined as often as reasonably necessary while a claim is pending.

L. Legal Actions: No legal action may be brought to recover on Your Certificate within 60 days after written proof of loss has been given as required by Your Certificate. No such action may be brought after 5 years from the time written proof of loss is required to be given.

M. Errors Related to Your Coverage: If the Company's records of Your coverage are in error due to a Company error or delay, the record will be corrected after discovery of the error. If Your premiums are affected, the Company may need to make a retroactive change in Your premiums. The Company will make appropriate changes in Your coverage and/or premiums to ensure that You have the coverage You are entitled to under this Certificate.

The Company has the right to correct benefit payments which are made in error. Providers and/or You have the responsibility to return any overpayments to the Company. The Company has the responsibility to make additional payments if an underpayment is made.

N. Statements Made by the Contract Holder or the Insured: A copy of the application, if any, of the Contract Holder shall be attached to the Contract when issued. All statements made by the Contract Holder or by the Insured will be deemed representations and not warranties. No statement made by an Insured will be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the Insured.

O. Notice

1. **From the Company to the Contract Holder.** A notice sent to the Contract Holder by the Company is considered given when mailed to the Contract Holder's address as it appears in the records of the Company.

2. **From the Company to an Insured.** A notice sent to an Insured by the Company is considered given when mailed to the Insured's address as it appears in the records of the Company.

3. **From the Contract Holder or an Insured to the Company.** Notice to the Company is considered given when received by the Company at 1133 SW Topeka Boulevard, Topeka, Kansas 66629. Any such notice should include the Insured's name and the identification number on the Identification Card.

P. Changes In this Contract: Benefits and premiums may be changed after approval by the Board of Directors of the Company and filing by the Kansas Insurance Commissioner.

No agent or representative of the Company other than its Board of Directors is authorized to change this Contract or waive any of its provisions.

Q. Notification of Change: The Contract Holder will be given notice of any benefit change by a new Group Contract, rider, amendment, or other means as permitted by law. If substantive changes to the Certificate issued thereunder are made, new Certificates or riders or amendments will also be issued.

R. Acceptance of Change: If premium payment is made to the Company after the effective date of any change to the Group Contract, such payment shall be deemed consent to that change.

S. Claims Recoveries

There may be circumstances in which the Company recovers amounts paid as claims expense from the provider of service, from the Insured or from a third party. Such circumstances include rebates paid to the Company by pharmaceutical manufacturers based upon amounts of claims paid by the Company for certain specified pharmaceuticals, amounts recovered by the Company from health care providers or pharmaceutical manufactures through certain legal actions instituted by the Company relating to the claims expense of more than one Insured, recoveries by the Company of overpayments made to health care providers or to Insureds, and recoveries from other parties with whom the Company contracts or otherwise relies upon for payment or pricing of claims. The following rules govern the Company's actions with respect to such recoveries:

1. In the event such recoveries relate to claims paid more than a year and 90 days before the recovery, no adjustment will be made to any Deductible or Coinsurance paid by an Insured and the Company shall be entitled to retain such recoveries for its own use. If the recovery relates to a claim paid within a year and 90 days and is not otherwise addressed herein, Deductible and Coinsurance amounts for an Insured will be adjusted for the applicable benefit period if affected by the recovery.
2. Such recoveries (except for recoveries made within a year and 90 days of the date of the error by the Company of overpayments to health care providers or to Insureds by the Company not involving assertion of a mass claim by the Company) will not be applied for the purpose of group rating or divisible surplus calculation, if applicable, in any event. The cost actually paid by the Company to procure such recoveries will be treated as an administrative expense in considering group rating or divisible surplus, if applicable. The amounts of recovery available in any event to be applied to the group claims expense will be reduced by the cost to the Company to procure that recovery, including amounts paid in attorney fees, amounts paid to collection agencies or other entities, where such entities obtain recoveries on a contingency basis.
3. In the event Blue Cross and Blue Shield of Kansas receives from pharmaceutical manufacturers rebates based upon amounts of claims paid by Blue Cross and Blue Shield of Kansas for certain specified pharmaceuticals, Blue Cross and Blue Shield of Kansas shall be entitled to retain such rebates for its own use, and no adjustments will be made to claims paid on behalf of the Contract Holder, to Deductible, Coinsurance or Copayments/Copays paid by Insureds, or to other cost-sharing or claims amounts.
4. If an Insured is no longer covered by the Company at the time any such recovery is made, regardless of the amount or of the time of such recovery, the Company shall be entitled to retain such recovery for its own use.
5. If such recovery amounts cannot be attributed on an individual basis, because of having been paid as a lump sum settlement for less than the total amount of claims expense of the Company or otherwise, no adjustments will be made to any Deductible, Coinsurance or Copayment/Copay amounts paid by the Insured and the Company shall be entitled to retain such recovery for its own use.
6. The amount of any recoveries which are otherwise available for adjustments to Deductible, Coinsurance or Copayments/Copays will be reduced by the cost to the Company to procure that recovery, including amounts paid in attorney fees, amounts paid to collection agencies or other entities obtaining recoveries on a contingency basis.
7. Under no circumstances shall such claim recoveries include subrogation.

T. For additional information regarding the benefits covered hereunder or to obtain a copy of the list of Contracting Providers that when used will assure that You are receiving the highest possible level of benefits available under Your Certificate, call the Customer Service phone number on Your Identification Card. Information You request about benefits and lists of Contracting Providers will be furnished without charge.

U. **Certificate of Creditable Coverage:** You have the right to request and obtain a Certificate of Creditable Coverage from the Company while You are an Insured and up to 24 months following the date on which Your coverage cancelled. To request a Certificate of Creditable Coverage contact the Customer Service phone number on Your Identification Card.

V. **Contract Holder's Responsibilities Concerning Enrollment:** It is the responsibility of the Contract Holder/employer group's Plan Administrator to submit to the Company for enrollment only those employees and dependents who meet the eligibility criteria of the Contract Holder and the Company, and to ensure and verify the continued eligibility status of covered employees and dependents. The Company has the right to recover from Insureds and/or providers any benefit payments paid on behalf of ineligible persons.

W. **Contract Holder's Responsibilities Concerning Federal Minimum Loss Ratio Rebates**

In the event the Company is required to provide rebates pursuant to 45 CFR 158.240 et.seq., the Contract Holder (and its member employers in the case of an association or multiple employer trust) shall be responsible for calculating the amount of each Certificate Holder's proportionate share and distributing such rebates to

Certificate Holders. Contract Holder (including on behalf of any member employers as noted above) also agrees to timely provide Company with rebate verification data required under 45 CFR 158.242 in the manner requested by the Company.

X. Choice of Law: The terms of this Certificate shall be construed solely pursuant to the taws of the state of Kansas to the extent not pre-empted by federal law.

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COORDINATION OF THIS GROUP CERTIFICATE'S BENEFITS WITH OTHER BENEFITS

This coordination of benefits (COB) provision applies when an Insured has health care coverage under more than one Plan. "Plan" is defined below.

The order of benefit determination rules below determines which Plan will pay as the Primary Plan. The Primary Plan that pays first pays without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all group Plans do not exceed 100% of the total allowable expense.

A. DEFINITIONS

1. A "Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate Certificates are used to provide coordinated coverage for Insureds of a group, the separate Certificates are considered parts of the same Plan and there is no COB among those separate Certificates.

   a. "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care; school accident-type coverages and governmental benefits, as permitted by law.

   b. "Plan" does not include: individual insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of $200 or less per day; group or group-type accident only coverage, benefits for non-medical components of group long-term care policies; Medicare; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law and the medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts.

   Each Certificate for coverage under a. or b. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

2. The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when compared to another Plan covering the Insured.

   When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

3. "Allowable Expense" means a health care service or expense, including deductible, coinsurance and copayment amounts, that is covered at least in part by any of the Plans covering the Insured. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an Allowable Expanse. The following are examples of expenses or services that are not Allowable Expenses.

   a. If an Insured is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the Insured's stay in a private hospital room is Medically Necessary, or one of the Plans routinely provides coverage for hospital private rooms) is not an Allowable Expense.

   b. If an Insured is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

   c. If an Insured is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, or if one Plan calculates its benefits or services on the basis of usual and customary fees and another Plan provides its benefits or services on the basis of negotiated fees, any amount in excess of the highest of the fees is not an Allowable Expense.

   d. The amount a benefit is reduced by the Primary Plan because an Insured does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

4. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which an Insured has no coverage under this Plan, or before the date this COB provision or a similar provision takes effect.

5. "Closed Panel Plan" is a Plan that provides health benefits to Insureds primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

B. ORDER OF BENEFIT DETERMINATION RULES

When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

1. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.
2. A Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
3. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
4. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

   a. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Plan is primary.

   b. Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one Plan is:

      (1) The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

      (2) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods or plan years commencing after the Plan is given notice of the court decree.

      (3) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

      - The Plan of the custodial parent;
      - The Plan of the spouse of the custodial parent;
      - The Plan of the noncustodial parent; and then
      - The Plan of the spouse of the noncustodial parent.

   c. Active or Inactive Employee. The Plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an 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 is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled B.4.a.

   d. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. 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 is ignored.

e. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is primary.

f. If the preceding rules do not determine the Primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this regulation. In addition, this Plan will not pay more than it would have paid had it been primary.

C. EFFECT ON THE BENEFITS OF THIS PLAN

1. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than 100% of total allowable expenses. The difference between the benefit payments that this Plan would have paid had it been the Primary Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this Plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this Plan will:

   a. Determine its obligation to pay or provide benefits under its contract;

   b. Determine whether a benefit reserve has been recorded for the Insured; and

   c. Determine whether there are any unpaid allowable expenses during that claims determination period.

   If there is a benefit reserve, the Secondary Plan will use the Insured's benefit reserve to pay up to 100% of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

2. If an Insured is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

D. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Company any facts it needs to apply those rules and determine benefits payable.

E. FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

F. RIGHT OF RECOVERY

If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

CANCELLATION

A. Cancellation of the Group Contract: The Group Contract can be canceled effective the date to which premiums have been paid, for several reasons.

Cancellation by the Company:

1. The Company may cancel the Group Contract for the following reasons:
   a. Nonpayment of premiums by the Contract Holder. The Contract Holder has a grace period of 10 days following the due date for payment of premiums. Unless premiums are received by the end of the stated grace period, coverage under this Certificate terminates as of the payment-due date.
   b. Fraud or intentional misrepresentation of a material fact by the Contract Holder, or employer.
   c. Non-compliance with provisions of this Contract.
   d. Failure to meet or maintain the participation or employer contribution requirements of the Company.
   e. The Company ceases to offer a particular type of group coverage provided the provisions of Kansas law associated with such action are met, (including but not limited to obligations to provide at least 90 days prior notice to contract holders and employers of the decision to cease to offer such coverage and the option such terminated groups have to purchase any other group coverage otherwise available from the insurer to a similarly situated group).
   f. If this Contract is issued to a small employer as defined by Kansas or federal law applicable to health insurance, the Company ceases doing business in the small employer market, provided that the provisions of Kansas law associated with such action are met, (including the obligation to provide notices at least 180 days prior to the date of the discontinuation of such coverage, to regulatory authorities, contract holders, and employers of the decision to cease to do such business, all group policies are discontinued and not renewed and the Company does not re-enter the small employer marketplace for five years from the date of notice).
   g. When there is no longer any eligible employee, member or dependent enrolled under this Contract who lives, resides or works in the Company Service Area.

   Cancellation for the foregoing reasons will be effective on the date specified by the Company in a written notice of termination.

Cancellation by the Contract Holder:

The Contract Holder may cancel the Group Contract by giving the Company 15 days advance written notice. Cancellation is effective the date to which premiums have been paid.

B. Termination of an Individual Insured's Coverage under the Group Contract: The coverage of an individual Insured will terminate in the following situations:

1. When the Company is notified that an Insured's coverage is to be removed from the group, the Insured's coverage under this Certificate will end as of the date the Insured's premiums are paid to. The Insured is not entitled to a grace period or benefits during a grace period.
2. Termination of marriage. The coverage of the husband or wife of the person named on the Identification Card ends on the last day of the month in which the divorce was granted by court action.
3. Children who no longer qualify under the general definition of "Insured".
4. Children who are age 18 or over and qualify under the general definition of "Insured" but for whom a written request to terminate coverage has been received.
5. If an Insured permits the use of their or any other Insured's Blue Cross and Blue Shield of Kansas Identification Card by any other person, or uses another Insured's card, all rights of the Insured(s) may be terminated effective immediately upon written notice.
6. If an Insured fails to disclose information requested by Blue Cross and Blue Shield of Kansas or intentionally misrepresents information provided to Blue Cross and Blue Shield of Kansas, then the rights of such Insured under this Certificate may be rescinded with a 30 days minimum written notice. At the effective date of such termination, prepayments received on account of such terminated Insured applicable to periods after the effective date of termination shall be refunded less nonrecoverable claims paid and the Company shall have no further liability or responsibility under this Certificate.
7. When an Insured is determined to be ineligible for coverage provided by this Contract Holder. All rights of the Insured may be terminated effective immediately upon written notice and coverage may be retroactively cancelled effective the first day of the month following the date on which the Insured became ineligible for coverage. At the effective date of such termination, prepayments received on account of such terminated Insured applicable to periods after the effective date of termination shall be refunded and the Company shall have no further liability or responsibility under this Certificate.

C. Reinstatement: If an Insured's coverage is canceled for non-payment of premiums by the Contract Holder (see A.1.a. above), the Company has the right to decide whether or not to reinstate the Group Contract. If coverage is reinstated, there will be no gap in coverage.

D. Benefits When Your Coverage is Canceled: Your coverage ends on the date of cancellation, except for an Insured who is receiving Inpatient Hospital services when that person's coverage terminates. In such case, benefits may be extended for that Insured without payment of premium for a period not less than 31 days following the termination date of the coverage. This extension of benefits shall be secondary to any subsequent replacement group health benefit plan or policy which is intended to provide continuous coverage.

This extension of benefits will be terminated upon the earlier of:

1. the completion of a 31 day period following termination of coverage; or
2. the date Hospital confinement ends.

E. When a grace period for payment of premiums is applicable, benefits are provided during the grace period only if premiums are received by the end of the stated grace period. The only Insureds who have a grace period are those canceled with the whole group under the nonpayment of premiums provision in subsection A.1.a. above.

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CONTINUED COVERAGE RIGHTS UNDER COBRA AND USERRA, CONTINUED COVERAGE UNDER KANSAS LAW AND CONVERSION

A. COBRA Continuation Coverage - Federal Law

This law applies to employers whose payroll included 20 or more employees during the previous calendar year and such employer's group health plans, not to insurance contractors or third party administrators. That is, if Your employer changes from Blue Cross and Blue Shield of Kansas to another insurance carrier or third party administrator (in the case of a self-funded arrangement), the right to continuation under federal law remains with the employer through the new carrier or to claims adjudication under the new administrator.

CONTINUOUS COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. If You have recently become covered under the group health plan of the Group Contract Holder (the Plan) or have changed to a type of coverage that includes coverage for Your spouse and/or dependent child(ren), this is the initial notice of COBRA continuation coverage rights. Otherwise, this section is included as part of this Certificate for informational purposes. This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to You when You would otherwise lose Your group health coverage. It can become available to You and to other members of Your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about Your rights and obligations under the Plan and under federal law, You should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

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 notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary" You, Your spouse, and Your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You are an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from Your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child".

If the group health plan offered by Your employer includes coverage for retired employees, 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 entity identified on the face page of this Certificate, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after Your employer's Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, for group health plans that include coverage for retired employees commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify Your employer's Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), You must notify Your employer's Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to Your employer's Plan Administrator.

How is COBRA Coverage Provided?

Once Your employer's 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 employees 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), Your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuous coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled and You notify Your employer's Plan Administrator in a timely fashion, You and Your entire family 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 continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If Your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website)

Keep Your Plan Informed of Address Changes

In order to protect Your family's rights, You should keep Your employer's Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to Your employer's Plan Administrator.

Plan Contact Information

USD 262 VALLEY CENTER
143 S Meridian Ave.
Valley Center, KS

The Company has agreed with the employer to undertake only limited duties with respect to COBRA as set forth below.

1. **Payment of Premiums**

   Upon receipt of the COBRA Declaration Form, the Company will send the employee or dependent who qualifies for COBRA continuation of benefits a notice of the amount of premiums needed for the continued benefits. A period of 45 days (from the date of election/declaration) is allowed in which to pay the initial required premiums. The first premium payment will be for a period commencing with the date following the date coverage would otherwise terminate. No gap in coverage will be permitted. The premiums may be higher than for active employees, as permitted by law.

   Subsequent premium payments will be allowed a 30-day grace period after the due date. The Company will bill the Insured directly and payment will be made directly to the Company.

2. **Enrollment and Benefit Changes**

   a. If the group changes benefits, the COBRA Insured's benefits will also change to match the group's new benefit package.

   b. The COBRA Insured has the same right to change benefit programs as the active group employees. If the active employee is allowed to change from HMO coverage to a traditional coverage during the employer's Open Enrollment period, a COBRA Insured is allowed the same opportunity. Transfers which will impose a pre-existing waiting period will not be permitted.

   c. If the employer changes insurers during the period of Continued Group Benefits, the COBRA Insured for that group will be canceled as to coverage under this Certificate and become the responsibility of the new insurer.

   d. The Company shall not be obligated to provide COBRA coverage to You if the Contract Holder or Plan Administrator fails to timely notify You of Your rights under COBRA or You fail to timely elect COBRA coverage.

3. **Conversion Privilege**

   COBRA Insureds who complete the COBRA Continuance of Benefits period are then eligible for a conversion contract offered by Blue Cross and Blue Shield of Kansas at the conversion contract rates then in effect. This conversion is only applicable to Insureds whose group offers health insurance with Blue Cross and Blue Shield of Kansas at the time the Insured's eligibility under COBRA ends. Section D describes the conversion privilege in more detail.

B. USERRA Continuation Coverage - Federal Law

USERRA applies to ALL employer groups even if COBRA does not apply to the employer.

The right to USERRA continuation coverage was created by a federal law, the Uniformed Services Employment and Re-employment Rights Act of 1994 and amendments (USERRA).

Continuation and Reinstatement of Coverage on Account of Qualified Uniformed Service. Apart from the rights to continued coverage described in the preceding information, if applicable, You may be entitled to continue certain aspects of Your coverage (on a self-pay basis) during a period of Qualified Uniformed Service. You also may have certain reinstatement rights following a period of Qualified Uniformed Service. The specific rules are as follows:

1. **Persons Eligible for Continued Coverage.** An employee who is absent from the employment of his or her employer on account of a period of Qualified Uniformed Service may continue employee and dependent medical coverage on a self-pay basis for the 24 month period beginning on the date on which the employee is first absent from employment by reason of Qualified Uniformed Service. Coverage will terminate on the day after the date on which the employee fails to apply for or return to a position of employment, if the failure to apply or return terminates the employee's right to reemployment rights under applicable federal law regarding uniformed service.

2. **Cost of Continued Coverage**. The monthly charge for continued coverage will be determined by the Company, and will be the same for all similarly situated individuals electing the same type of coverage under this provision. If any single period of Qualified Uniformed Service is for a period of less than 31 days, the only amount required to be paid by the employee is the amount, if any, the employee would pay

if he or she had not entered Qualified Uniformed Service. In other cases, the employee's charge will reflect both the employee's portion and the employer's portion, determined in the same manner as COBRA charges.

3. **Benefits Subject to Continuation.** Any election made by an employee applies to the employee and the employee's dependents who otherwise would lose coverage under this Certificate. No separate election may be made by any dependent. The medical coverage that employees are allowed to continue on behalf of themselves and their dependents will be the same as that provided to employees and their dependents under the Plan. Except in connection with circumstances that permit other employees to make changes, an employee may continue only the type of coverage that he or she was receiving on the day before the employee first was absent from employment.
4. **Election of Continued Coverage**. An employee eligible to continue coverage under this provision will be sent an application for continued coverage within 30 days after the Company receives notice, satisfactory to the Company, that the employee will be, or is, absent from employment for a period of Qualified Uniformed Service. If an employee wishes to have coverage continued, he or she must complete the application and return it to the Company within 60 days from the later of the date the application is sent or the date coverage otherwise would terminate.
5. **Payment for Continued Coverage.** The continuation of coverage is conditioned on an employee's payment of the monthly charges for the coverage, determined from the date coverage otherwise would terminate, even if the employee waits 60 days from that date to return the application. If an employee elects continued coverage, payment must be made, relating back to the date that coverage otherwise would terminate, within 45 days after the date the employee elects to continue coverage. After that, payments must be made by the first day of each month for which coverage is to be provided, subject to a 30-day grace period.
6. **Interaction with COBRA** (if applicable):

   Generally, rights to USERRA and COBRA continuation coverage run concurrently from the commencement of Qualified Uniformed Service. Accordingly, employees and/or their dependents may have continuation rights that extend beyond 24 months.
7. **Reemployment Rights**

   If Your coverage has been terminated as a result of the service member's failure to elect continuation coverage, or the service member's length of service, at the time of the service member's reemployment no exclusions or waiting period may be imposed where one would not have been imposed if the coverage of the service member had not been terminated as a result of service in the uniformed services. This provision does not apply to any condition (illness or injury) determined by the Secretary of Veterans Affairs to have been incurred or aggravated during service, however, the service member and any dependents must be reinstated as to all other medical conditions covered by this Certificate.

C. Kansas State Continuation Law

The following provisions of Kansas laws governing group health insurance benefits for hospital, surgical and medical services apply to persons who do not have a right to continue coverage under the federal law.

An employee or such person's covered dependents, whose hospital, surgical or major medical expense insurance (and dental insurance in conjunction with the aforementioned) under the Group Contract has been terminated for reasons such as discontinuance of the Group Contract in its entirety or with respect to an insured class of persons, is entitled to have such continuation coverage under the Group Contract, subject to the following provisions:

1. The employee or covered dependent must have been continuously insured under the Group Contract (or a group policy providing similar benefits which was replaced by the Group Contract) for at least three (3) months immediately prior to termination.
2. Such group benefits may be continued under the Group Contract for a period of 18 months.

   Clarification:

   A dependent whose eligibility as a dependent ceases during the 18-month period may complete the 18-month period under separate coverage.
3. Continuation of group benefits does not apply:
   a. Where persons are on continuation coverage and during that 18-month period the Group Contract is replaced. Such persons for that group will be canceled as to coverage under this Contract and become the responsibility of the new insurer.
   b. When termination of coverage under the Group Contract occurs because any employee failed to pay any required contribution.
   c. When the employee is or could be covered by Medicare.

d. When the employee is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination.

e. When coverage for an Insured is terminated pursuant to items B. 5, 6 or 7 of the Cancellation Section.

4. Notice of Right to Continue Group Benefits: The Insured named on the Identification Card will be notified of their right to continue their group benefits. The Insured must provide written notification that they wish to continue their group coverage to the Company within 60 days of the date an event occurs which would qualify an Insured for continuation coverage under this provision. Upon receipt of the written notification from the Insured, the Company will send the employee or dependent who qualifies for continuation of group benefits a notice of the amount of premiums needed for the continuation benefits. A period of 45 days from the date the Insured elects to continue group benefits is allowed in which to pay the initial required premiums. The first premium payment will be for a period commencing with the date following the date coverage would otherwise terminate. No gap in coverage will be permitted.

   Subsequent premium payments will be allowed a 30-day grace period after the due date. The Company will bill the Insured directly and payment will be made directly to the Company.

D. Conversion Privilege

1. A conversion privilege is available to the following persons:

   a. Those who have completed the period of Continued Group Benefits provided for in Section A, B, or C above if Blue Cross and Blue Shield of Kansas is the insurer or administrator of that employer group health plan at the termination of such benefits.

   b. Those who during the period of Continued Group Benefits provided for in Section A, B, or C above choose to change to the Conversion Contract and so notify the Company. (So doing forever forfeits any right to further Continued Group Benefits.)

   c. Those who at the time of initial eligibility for Continued Group Benefits under Section A or B above choose to go directly at that time to the Conversion Contract. (So doing forever forfeits any right to Continued Group Benefits.)

   d. Those who do not qualify for Continued Group Benefits under either Section A or B above.

2. A conversion privilege is not applicable to Insureds who have their coverage terminated pursuant to items B.5, 6, or 7 of the Cancellation Section or to the following persons if the benefits referred to in paragraph b. below for such person or benefits provided or available under the sources referred to in paragraphs c. and d. below for such person, together with the benefits provided by the converted policy, would result in over-insurance based on Company standards as filed with the Kansas Insurance Department:

   a. Those who are or could be covered by Medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded).

   b. Those who are covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program, or

   c. Those who are eligible for similar benefits (whether or not covered therefore) under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, or

   d. Those who have or have available similar benefits pursuant to or in accordance with the requirements of any state or federal law.

3. Conversion Notice

   The Company will mail a conversion notice to those persons specified in Section D.1. Within 31 days of receipt of the notice, the person has the right to apply for coverage by remitting the required premiums. The first required premium payment will be for a period commencing with the day following the date coverage would otherwise terminate. No gap in coverage will be permitted.

   Persons who are enrolled in Continued Group Benefits will be mailed the conversion notice prior to the end of the period for continued group benefits.

   a. Notice to the Insured named on the Identification Card: The notice will be mailed to the Insured's latest address as it appears on the records of the Company.

   b. Notice to dependents who cease to be eligible: The notice will be mailed to the dependent at the address provided the Company when the Company is notified that such person is no longer an eligible dependent.

4. The contract does not require evidence of insurability of the person to be covered.

BLUE CHOICE RIDER

PART 1. GENERAL

This is a Rider to Your Certificate. It becomes effective on the date shown in the records of Blue Cross and Blue Shield of Kansas.

The conditions described in Your Certificate also control this Rider except where this Rider specifically states there is a change.

PART 2. ENROLLMENT IN BLUE CHOICE

The Contract Holder and Insured agree to the following related to the offering of Blue Choice and the Insured's enrollment therein:

A. Blue Choice Providers

"Blue Choice Provider" means an Institutional Provider or Professional Provider of health care services that has entered into an agreement with the Company under which it is classified as a Blue Choice Provider.

"Blue Plan Preferred Provider" means an Eligible Provider that has entered into an agreement with a Blue Cross and/or Blue Shield Company (other than Blue Cross and Blue Shield of Kansas) under which additional deductibles and/or coinsurances for use of a non-preferred provider do not apply to such Eligible Provider.

The Company will provide the Contract Holder with listings of the Blue Choice Providers in the Company Service Area. You may call the number listed on the Insured's Identification Card if You wish to determine if a provider outside the Company Service Area is a Blue Plan Preferred Provider.

B. Use Blue Choice Providers or Blue Plan Preferred Providers

To receive the maximum level of benefits from Your Blue Choice coverage, You must use Blue Choice or Blue Plan Preferred Providers. Section C describes the lesser benefits when non-Blue Choice Providers or non-Blue Plan Preferred Providers are used.

C. Additional Coinsurance

You will be responsible for an additional 20% of the Allowable Charge up to a maximum additional coinsurance of $2,000 per Insured per Benefit Period or $4,000 for all Insureds on family coverage per Benefit Period that would otherwise be allowable if You fail to use a Blue Choice Provider or a Blue Plan Preferred Provider. This additional coinsurance does not accumulate toward the satisfaction of any other deductible, coinsurance or shared payment called for by Your Certificate, and those other deductibles, coinsurances or shared payment amounts called for by Your Certificate continue to apply.

The additional coinsurance is not applied when service is required for a Medical Emergency or a life, limb, or function-threatening Accidental Injury.

The Company has no obligation to advise You of the applicability of additional coinsurances for use of a non-Blue Choice Provider or a non-Blue Plan Preferred Provider during the course of pre-authorization or otherwise. You are responsible for choosing their providers of health care services.

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SUPPLEMENTAL ENDORSEMENT ISSUED BY BLUE CROSS AND BLUE SHIELD OF KANSAS, INC.

As a Blue Cross and Blue Shield of Kansas Insured You have the opportunity to take advantage of savings programs that are collectively called Resource Blue which are being offered at no additional cost to You. These programs are not insurance but instead discount programs that will help You with specified expenses for services that are not eligible for coverage under Your Blue Cross Blue Shield of Kansas coverage.

The types of services included are:

- Vision Care
- Hearing Care
- Complementary and Alternative Medicine

Disclaimer

The above savings programs are made possible through arrangements with various providers and vendors. Changes in these arrangements and/or their discontinuance may occur in the future at the discretion of Blue Cross and Blue Shield of Kansas.

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APPENDIX B
DENTAL PLAN

This Appendix B contains the terms and conditions specific to the USD #262 Valley Center Dental Plan that may be elected under Section 4.01 of the Plan. Unless otherwise altered by the terms of this Appendix B, the terms and conditions of the Plan are incorporated into, and made applicable to, this Dental Plan.

Section B1.01 Eligibility/Plan Entry Dates. The eligibility conditions and the Dental Plan entry dates are the same as those for the Plan.

Section B1.02 Dental Benefits. Benefits under this Dental Plan are identical to those described in, and shall be paid pursuant to the terms of, the Group Contract ("Delta Dental of Kansas Group Contract") between Delta Dental of Kansas ("Delta Dental") and the Employer (Group No. 52109/52110). The provisions of that contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by Delta Dental. The Employer makes no promise, and shall have no obligation, to provide or pay such benefits from its own assets. The rights and conditions with respect to the benefits payable under this Dental Plan shall be determined from the Delta Dental Group Contract. The Participant shall bear fully any and all risk of Delta Dental's insolvency.

Section B1.03 Cost of Coverage. The Participant's monthly premiums are determined pursuant to the Delta Dental Group Contract. Under the terms of the Group Contract, Delta Dental may change the premiums from time to time. The Participant must pay the cost of the monthly premium for coverage on a pre-tax basis. The Employer will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant.

Section B1.04 Election to Participate. A Participant who desires to receive dental insurance coverage under this Dental Plan must elect to participate in this Dental Plan and must make arrangements to pay his/her share of the applicable premium. If a Participant does not elect to receive dental coverage under this Dental Plan, the Employer will not provide him/her with any dental insurance coverage.

Section B1.05 Payment of Premium. A Participant who has elected to participate in this Dental Plan may pay the applicable premium on a pre-tax basis by entering into a salary reduction agreement pursuant to the terms and provisions of the Plan. Except for those Participants who are (a) exercising their right to continuation coverage pursuant to Section B1.06 below, (b) exercising their right to continue coverage during a qualifying unpaid leave pursuant to Section 3.03, or (c) eligible pursuant to Section 2.12(b), all premiums must be paid through pre-tax salary reductions.

Section B1.06 Continuation of Coverage. An individual who will lose coverage under this Dental Plan may have the right to continue coverage under this Dental Plan as described in Article VIII.

Section B1.07 Children Subject to a NMSN. Children who are the subject of a National Medical Support Notice ("NMSN") shall become "alternate recipients" of benefits under this Dental Plan in accordance with such order. The Plan Administrator shall establish reasonable procedures to determine the qualified status of a NMSN. Upon receiving a NMSN, the Plan Administrator shall promptly follow the instructions on such NMSN.

Section B1.08 Claims Administration. Delta Dental will act as Claims Administrator with respect to any claim for benefits under this Dental Plan. Delta Dental has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the Group Contract. Except as provided by law, all decisions of the Claims Administrator shall be final and binding.

Section B1.09 Termination of Participation. A Participant ceases to be a Participant as of the earliest of the following:

(a) The last effective date of coverage – as specified by the insurance Group Contract – following the Participant's termination of employment with the Employer;

(b) The date on which the Participant's election to participate expires;

(c) The end of a period for which a required contribution by the Participant was last paid, taking into account any grace periods required by law;

(d) The last effective date of coverage – as specified by the insurance Group Contract – following the date on which the Participant ceases to be an Eligible Employee; or

(e) The date on which this Dental Plan terminates.

Notwithstanding anything in this Section to the contrary, an individual who would normally be required to terminate participation may continue to be a Participant in this Dental Plan if and to the extent such individual elects continuation of benefits under the rules in Section B1.06.

Section B1.10 Character of Benefits Provided. This Dental Plan does not provide dental treatment or advice. It merely pays for the cost of selected benefits as described in, and in accordance with, the provisions of the Group Contract. The fact that a particular dental service may not be eligible for reimbursement under this Dental Plan does not mean that a Participant or other person who is covered under this Dental Plan should not receive that service.

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Welcome to Delta Dental of Kansas, Inc.

Delta Dental of Kansas, Inc. is a member of Delta Dental Plans Association, the leading and largest underwriter of group dental coverage in the United States. Together with your employer, we have designed a dental benefit plan to help protect the oral health of you and your covered dependents. Regular preventive dental care not only reduces the cost and the pain generally associated with extensive dental work, but a healthy mouth contributes to the overall well-being of every person.

You are free to go to any dentist of your choosing; however, there may be a difference in payment if the dentist is not a participating dentist with Delta Dental. Since over 75% of the dentists do contract with Delta Dental, the chances are excellent your dentist is already a member. If you have any questions about whether your dentist participates with Delta Dental, ask your dentist when making an appointment or contact the Customer Service staff at Delta Dental of Kansas, Inc. by calling (316) 264-4511 or toll free (800) 234-3375. You may also access our network, nationwide, through our website at www.deltadentalks.com.

From our website, you can

- Check your eligibility and plan information
- Print yourself an ID card
- Check claim status
- Locate a participating **Delta Dental Premier** dentist
- Learn about oral health and wellness
- Use our flexible spending account estimator

It is our pleasure to be of service to you.

Summary of Dental Plan Benefits

U S D #262 - VALLEY CTR-HIGH

Group #52110-000-00001-00000

% paid by Plan				Examples of Covered Services
DIAGNOSTIC & PREVENTIVE (Not subject to Deductible)				
PPO Network	**Premier Network**	**Non Network**		
100%	**100%**	**100%**	**I.**	**DIAGNOSTIC**: Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: Oral evaluations – two (2) times per Contract year. Bitewing x-rays – bitewings two (2) times per Contract year for dependents under age eighteen (18) and once (1) each twelve (12) months for adults age eighteen (18) and over. Full mouth or panoramic x-rays – once (1) each five (5) years.
100%	**100%**	**100%**	**II.**	**PREVENTIVE:** Provides for the following: Prophylaxis (Cleanings) – two (2) times per Contract year. Topical Fluoride – two (2) times per Contract year for dependent children under age nineteen (19). Space Maintainers for dependent children under age fourteen (14) and only for premature loss of primary molars. Sealants – once (1) per tooth per lifetime for dependent children under age sixteen (16) when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.
BASIC (Subject to Deductible)				
50%	**50%**	**50%**	**III.**	**ANCILLARY:** Provides for one (1) emergency examination per Plan year by the Dentist for the relief of pain.
50%	**50%**	**50%**	**IV.**	**ORAL SURGERY:** Provides for simple extractions only.
50%	**50%**	**50%**	**V.**	**REGULAR RESTORATIVE DENTISTRY**: Provides amalgam (silver) restorations, composite (white) resin restorations; and stainless steel crowns for dependents under age twelve (12).

% paid by Plan				Examples of Covered Services
BASIC (continued) (Subject to Deductible)				
PPO Network	**Premier Network**	**Non Network**		
50%	**50%**	**50%**	**VI.**	**PERIODONTICS:** Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is counted toward the frequency limitation for prophylaxis cleanings.
MAJOR (Subject to Deductible)				
50%	**50%**	**50%**	**VII.**	**ORAL SURGERY:** Provides for surgical extractions (excluding simple extractions) and other oral surgery including pre and post-operative care.
50%	**50%**	**50%**	**VIII.**	**ENDODONTICS**: Includes procedures for root canal treatments and root canal fillings. When covered, payment for root canal therapy is limited to only once (1) in any twenty-four (24) month period, per tooth.
50%	**50%**	**50%**	**IX.**	**PERIODONTICS:** Surgical periodontal procedures.
50%	**50%**	**50%**	**X.**	**SPECIAL RESTORATIVE DENTISTRY:** When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
			XI.	**PROSTHODONTICS**:
50%	**50%**	**50%**	a.	Includes bridges, partial and complete dentures.
50%	**50%**	**50%**	b.	Repairs and adjustments of bridges and dentures.
ORTHODONTICS (Subject to Deductible)				
50%	**50%**	**50%**	**XII.**	**ORTHODONTICS**: Includes orthodontic appliances and treatment, interceptive and corrective, for dependent children under age nineteen (19). Subject to limitations in "Exclusions and Limitations" Section.

A Covered Service is deemed to be benefited by DDKS if it is reimbursable, in whole or in part, under the terms of the Plan or would otherwise be reimbursable, in whole or in part, except for the application of a deductible, co-insurance payment, waiting period, frequency limitation, annual or lifetime benefit maximum, or other limitation contained in the Plan. For a Covered Service benefited by DDKS through payment, DDKS will pay the lesser of i) the percentage of the fee actually charged for a Covered Service which is indicated in the Summary of Dental Plan Benefits, or ii) in the amount which is otherwise pay in accordance with other provisions of the Plan.

This is a Summary of Benefits only, and various exceptions and limitations may apply. Your actual coverage is described in the Agreement which is binding on all of the parties and supersedes all other written or oral communications.

SEE SECTION ON EXCLUSIONS AND LIMITATIONS FOR ADDITIONAL INFORMATION

Selected Network
The Dental Networks for this Agreement are Delta Dental Premier and PPO.

Maximum Benefit(s) Per Person
Regular Services:
The Maximum Benefit for all Covered Services for each Enrollee in any one contract Year is One Thousand Dollars ($1000.00).

Orthodontic Services:
The Maximum Benefit for Orthodontic Services for each Enrollee is One Thousand Dollars ($1000.00) during such person's lifetime. Payment for Orthodontic Services shall not be included in determining the Maximum Benefit for each contract Year.

Deductible Limitations
Coverage for Diagnostic and Preventive Services is not subject to the Deductible. However, the Deductible shall apply during each contract Year to all other Covered Services which are provided to each Enrollee.

After Enrollees have, in any contract Year, each paid either the individual Deductible of Fifty Dollars ($50.00), or have cumulatively paid charges for Covered Services in the amount of One Hundred Fifty Dollars ($150.00), the deductible requirements of the preceding sentence shall no longer be applicable for any Covered Services during the remaining portion of that contract Year.

Payment of Claims
Before paying claims, DDKS may require reasonable evidence of the payment of Deductibles.

Eligible Children Ages
Children are eligible for coverage to age 26.

DESCRIPTION OF DENTAL CARE COVERAGE

This Description of Dental Care Coverage is issued to the Subscriber by Delta Dental of Kansas, Inc., hereinafter referred to as "DDKS", a nonprofit dental service corporation incorporated under the laws of Kansas.

This document is intended to be an easy-to-read outline of the principal features of your dental coverage program and constitutes your summary of the Agreement and contains the provisions of your dental coverage. The Agreement between your Employer and DDKS is the controlling document for all benefits, terms and conditions and supersedes all other written or verbal communications regarding the Plan. Only the cost of dental procedures necessary to eliminate oral disease or for appliances or restorations required to replace missing teeth are benefits under the Agreement and then only if identified as a covered dental benefit in the "Summary of Dental Plan Benefits" section. Certain restrictions may be applicable to your coverage. It is important to review the "Exclusions and Limitations" section of this document for these conditions.

If any state or federal legislation or regulation is in effect, enacted, or amended mandating a change in the dental benefits described in this booklet, appropriate modifications will be made in the benefits provided under the Agreement.

HOW TO USE YOUR PLAN

Make an appointment with your Dentist. Tell the Dentist that you are covered by Delta Dental of Kansas, Inc.

If the planned treatment involves prosthodontic or orthodontic procedures, individual crowns (except stainless steel), gold restorations, surgical periodontics, endodontics or oral surgery, except for simple extraction of a single tooth, the Dentist should submit a treatment plan to DDKS to determine how much of the bill will be paid by DDKS and what your share of the cost will be. Failure by your Dentist to predetermine benefits may result in a higher cost to you than anticipated if, in the professional judgment of DDKS's consultant, the treatment is not necessary or a lesser procedure could have restored the tooth to contour and function. Even if the Dentist does predetermine benefits, however, it does not obligate DDKS if you as an employee or dependent are no longer eligible for benefits at the time the services are actually performed or your Dentist was not a Participating Dentist with Delta Dental at the time services were performed. The treatment must commence within ninety (90) days of the date the treatment plan is submitted to DDKS by the treating Dentist or a new treatment plan should be obtained and resubmitted to DDKS.

PAYMENTS FOR COVERED SERVICES

Following treatment, the Dentist should forward the attending Dentist's statement to DDKS. If the Dentist is a Participating Dentist, DDKS will make direct payment to the Dentist for each Covered Service. If the Dentist is not a Participating Dentist, DDKS will pay the Employee on each Covered Service. The amount of payment will be calculated using the percentage amount indicated in the "Summary of Dental Plan Benefits" section

in this booklet. If more than one percentage column is shown in the Summary of Dental Plan Benefits, the percentage used will be the one that corresponds to the network status of the Dentist at the time the Covered Services are rendered. DDKS will pay for each Covered Service, subject to the Coordination of Benefits (COB) stipulations in the "Non-Duplication of Benefits" section of this booklet, based on the lesser of i) the fee submitted by the Dentist for the Covered Service, or ii) the Maximum Plan Allowance (MPA). For more information on MPA, see the definition of MPA in the "Definitions" section of this booklet.

You will receive notice of the Plan's payment and the amount, if any, that you owe the Dentist. The amount you owe should be paid in accordance with the Dentist's usual billing procedure.

NO PRE-EXAMINATION

There are no pre-examination requirements for employees and dependents to be eligible for dental benefits.

EMERGENCY TREATMENT

Each individual dental office has its own emergency treatment protocol and Enrollees should contact their Dentist and familiarize themselves with the procedure for emergencies that occur outside the Dentist's normal business hours. Hospital or medical service emergency room expenses are <u>not</u> covered benefits under the Plan.

INQUIRIES/APPEALS

Enrollees are encouraged to contact DDKS when they have a question concerning a particular claim. Such inquiry should be directed to the DDKS Customer Service Department. Telephone inquiries may be directed to the following numbers: in Wichita, 316-264-4511 or from outside of the Wichita area, 1-800-234-3375.

If a claim for benefits is denied in whole or in part, written notification called an "Explanation of Benefits" will be provided within thirty (30) days after a claim is received, unless special circumstances require an extension of time for processing. If additional time is necessary, DDKS will notify the Enrollee and/or the treating dentist of the reason for the additional time, including a description of additional information that is necessary to process the claim if information is missing. If additional information is necessary, the Enrollee will have forty-five (45) days to provide the additional information or else the claim will be decided based upon the information then available to DDKS.

Enrollees have the right to appeal a claim determination if the requested dental benefits were not paid in full. In order to appeal a benefit determination, Enrollees or their authorized representative must write to the Customer Service Department, Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, KS 67278-9769 within one hundred eighty (180) days of the date of the Explanation of Benefits for the claim. Written appeals

should be submitted with a copy of the Explanation of Benefits form for the claim in question and should include all of the following:

1. Employer group number and member identification number.
2. Subscriber's name and birth date. If the Enrollee is not the Subscriber, the Enrollee's name and birth date must also be included.
3. Dentist name and, if known, license number.
4. Claim number.
5. Date(s) of service.
6. An explanation of the complaint or question, including the basis for appeal.
7. Any additional information that the Enrollee believes supports his/her position.

A full and fair evaluation of the appeal will be made by DDKS and, in some cases the Enrollee may be examined clinically. If necessary, additional information or documents may be requested. Some matters may also be referred to the dental licensing board or to the applicable state dental association peer review system.

Normally, Enrollees will receive a written acknowledgement of their inquiry or appeal within twenty (20) days of DDKS' receipt. However, if the matter is referred to a review committee, or other unusual circumstances arise, the Enrollee will be advised. Generally, a written answer or decision will be sent to the Enrollee within thirty (30) days thereafter, however, DDKS must provide a written answer or decision within sixty (60) days receipt of the appeal.

If DDKS denies any part of the claim on appeal, DDKS will provide the Enrollee written notice of the basis for the denial and additional information. The Enrollee may request, free of charge, a copy of any applicable rules, exclusions, or limitations relied upon in the benefit determination. In addition, DDKS will provide the Enrollee with a copy of the documents relevant to the benefit determination free of charge upon request.

If the dental plan at issue is governed by the Employee Retirement Income Security Act, an Enrollee may have the right to bring a civil action under Section 502(a). In addition, an Enrollee may be entitled to additional levels of review and/or other voluntary alternative dispute resolution options, such as mediation under his/her group dental plan.

REEVALUATION AND REVIEW

If the Employer or Enrollee does not agree with the determination of benefits and has additional information to supply, reevaluation may be requested by resubmitting a copy of the claim form, x-rays and clinical comments to the Customer Service Department, Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, Kansas 67278-9769. The review of a claim form and x-rays may not be sufficient to appropriately resolve a matter in all cases. Accordingly, in some cases DDKS may rely on its regional dental consultants to examine patients clinically. When appropriate, examinations may also be conducted at the request of the Enrollee, a treating Dentist, or for other reasons determined by DDKS.

DDKS LIABILITY

DDKS shall have no liability for any wrongful conduct of any third party, including but not limited to tortuous conduct, negligence, wrongful acts or omissions, or any other act of any such person including but not limited to employees, Enrollees, Dentists, dental assistants, dental hygienists, hospitals, or the agents or employees of any of such foregoing persons, whether receiving or providing services. Further, DDKS shall also have no liability for any services or facilities which, for any reason, are unavailable to any Enrollee.

RIGHT TO INFORMATION

As a condition precedent to the approval of claims hereunder, DDKS, shall be entitled to receive from any attending or examining Dentist, or from hospitals or clinics in which a Dentist's care is rendered, such information and records relating to attendance to, or examination of, and/or treatment rendered to, an Enrollee. DDKS, at its own expense, shall have the right to cause any Enrollee to be examined when and so often as DDKS reasonably deems necessary during the pendency of a claim under the Agreement (including the right and opportunity to make an autopsy if it is not prohibited by law). The acceptance by any Enrollee of any benefit of coverage under the Agreement constitutes the Enrollee's (and the related Subscriber's, if applicable) automatic and irrevocable consent to the release to DDKS of any and all of the information and records before described, and a full waiver by that Enrollee that any such information and records that otherwise is privileged. Further, by providing Covered Services to an Enrollee, a Dentist or other service provider consents to, upon request, provide such information and records to DDKS as DDKS requests.

MISREPRESENTATIONS

No statements made by the Employer, or any other person, shall be deemed a warranty or shall be used in defense of a claim or in any other dispute under the Agreement, unless it is contained in a written instrument, a copy of which has been agreed to in writing by Employer and DDKS.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the Agreement prior to the expiration of sixty (60) days after the final written notice determining the status of a claim for breach has been delivered in accordance with the requirements of the Agreement. Further, and in all events, any action of any kind by any person who is subject to the Agreement must be commenced within five (5) years from the date on which the right, claim, demand, or cause of action shall first accrue.

GOVERNING STATUTES

Any provision of the Agreement which is in conflict with any applicable law is hereby amended to the minimum requirements of such law.

GOVERNING LAW

Except to the extent preempted by the Employee Retirement Income Security Act of 1974 (ERISA), the laws of the State of Kansas (irrespective of choice of law principles) shall govern the validity of the Agreement, the construction of its terms and the interpretation of the rights and duties of the parties. Any action brought to enforce, construe, or interpret the Agreement (including but not limited to any mediation or arbitration but only if arbitration is voluntarily agreed to by the parties at the time a dispute arises) shall be commenced and maintained in a location mutually agreeable by the parties to the dispute. Except to the extent preempted by ERISA, the parties irrevocably consent to the exclusive jurisdiction and venue in the court mutually agreed to by the parties for such purpose and agree not to seek transfer or removal of any action commenced in connection with the Agreement.

DEFINITIONS

For the purpose of this Description of Dental Care Coverage, the following definitions shall apply:

1. "Agreement" means the agreement between DDKS and Employer, including the Group Application, the attached appendices, endorsements and riders, if any. The Agreement constitutes the entire agreement between the parties.

2. "Benefit Booklet" means this written summary of certain features of the Plan.

3. "Child" or "Children" means, in addition to the Subscriber's own or lawfully adopted unmarried child or children, any unmarried step-child of the Subscriber residing with the Subscriber in a regular parent-child relationship so long as said child is not eligible to enroll in an "eligible employer-sponsored health plan" as defined by federal law. The term "Child" also includes any unmarried person placed with the Subscriber for adoption if such child was placed in the Subscriber's home by a child placement agency as defined by Kansas law, and any unmarried child of the Subscriber who is recognized as an alternate recipient under a qualified medical child support order. A child is eligible for coverage under the Plan if the child meets the age requirements as set forth in the "Eligible Children Ages" section.

   In addition, a Child includes an unmarried disabled Child who is: i) incapable of earning his or her own living because of mental or physical disability, and ii) principally dependent upon the Subscriber for support at the time the Child would otherwise cease to be eligible for coverage by the Plan because of age. A disabled Child shall continue to be an Eligible Dependent for the duration of the disability, provided: i) his or her status as an Eligible Dependent does not terminate for any other reason, and ii) proof of disability is furnished to DDKS within thirty-one (31) days after Child attains the age which would otherwise be disqualifying. Such proof of disability must thereafter be furnished from time to time as required by DDKS.

4. "Continuation Coverage" means the coverage provided under the Agreement pursuant to Section 4980B of the Internal Revenue Code of 1986, as amended

("Code"). All of the requirements, definitions and specifications of said Section 4980B of the Code which are necessary in order for the Agreement to satisfy Section 4980B of the Code, are being hereby adopted and incorporated by reference.

5. "Contract Year" means the period commencing on the Effective Date and terminating at 11:59 P.M. on the day preceding the anniversary thereof.

6. "Calendar Year" means the twelve (12) month period commencing on the first day of January and terminating at 11:59 P.M. on the last day of December.

7. "Cosmetic" means those services provided by Dentists for the purpose of improving the oral appearance when form and function are otherwise satisfactory. The determination of whether services are "Cosmetic" shall be made by DDKS in its discretion. Cosmetic services are not Covered Services under the Plan unless a Cosmetic service is specified as a Covered Service in the "Summary of Dental Plan Benefits" section.

8. "Covered Services" means those dental services, procedures, and products that are benefitted by DDKS, in whole or in part, pursuant to the terms of the Plan.

9. "DDKS" means Delta Dental of Kansas, Inc., which shall be the control plan, or any other Delta Dental Plans Association member company which has agreed to provide to Enrollees the benefits described in the Agreement, or both, as applicable.

10. **"**Deductible" means the amount specified in the "Summary of Dental Plan Benefits" section which must be paid with respect to Covered Services provided to an Enrollee before the Plan provides benefits.

11. "Dental Network" means one of the following networks as identified in the "Summary of Dental Plan Benefits" section:

    a.1. "**Delta Dental Premier":** The Delta Dental Premier network is a traditional fee-for-service network, and is the broadest network of Dentists that DDKS offers. All Delta Dental Premier providers are considered Participating Dentists and are paid according to DDKS' Participating Dentist Maximum Plan Allowance (MPA) as defined below. Non-Participating Dentists are <u>not</u> considered Delta Dental Premier Providers, and are paid according to DDKS' Non-Participating Dentist Maximum Plan Allowance.

    2. If Delta Dental Premier is the Exclusive Network, then Enrollees must exclusively use Dentists in the Delta Dental Premier network in order to receive the benefits provided by the Plan. If an Enrollee chooses a Dentist who does not participate in the Delta Dental Premier network, the Enrollee is responsible for <u>all</u> treatment costs incurred.

    b.1. **"Delta Dental PPO":** The Delta Dental PPO network is a subset of DDKS Participating Dentists who agree contractually to participate in the Delta Dental PPO network as part of a discounted fee-for-service plan. Delta

Dental PPO providers sign a supplemental agreement and are paid according to a Maximum Plan Allowance for PPO Dentists as defined below. Delta Dental PPO Dentists are paid at the in-network co-insurance percentages in the "Summary of Dental Plan Benefits" section, while Delta Dental Premier Dentists and non-participating Dentists are paid at the out-of-network co-insurance percentages in the "Summary of Dental Plan Benefits" section.

2. If Delta Dental PPO is the Exclusive Network, then Enrollees in the plan must exclusively use Dentists in the Delta Dental PPO network in order to receive the benefits provided by the Plan. If an Enrollee chooses a Dentist who is not a Delta Dental PPO Dentist, the Enrollee is responsible for all treatment costs incurred.

12. "Dentist" means any duly licensed dentist entitled to practice dentistry at the time and in the place the dental services are performed.

13. "Effective Date" means the first day of the initial term of the Agreement.

14. "Eligible Dependent" means i) the opposite sex spouse, as determined under applicable state law at the time and location that the marriage was entered into, ii) a Child of an Eligible Employee who satisfies the requirements of the definition of "Child" in Number 3 of this section of this booklet, and iii) any such spouse or Child who timely elects Continuation Coverage and for whom the appropriate premium is timely received by DDKS.

15. "Eligible Employee" means any person who meets the conditions of eligibility outlined in "Eligibility of Employees and Their Dependents" section, and any person who no longer meets such conditions but who timely elects Continuation Coverage and for whom the appropriate premium is timely received by DDKS.

16. "Employer" means the person(s) and/or entity(ies) named above which has hereby contracted with DDKS to provide the Plan described in the Agreement, and such members of the Employer's controlled or affiliated group which are specifically listed in the Group Application.

17. "Enrollee" means a person, whether an Eligible Employee or Eligible Dependent, who is i) eligible to be covered by the Plan, ii) validly enrolled in the Plan, and iii) for whom the appropriate premium is timely received by DDKS. An Enrollee shall be deemed to have enrolled when such Enrollee's name, enrollment information and the required premium are furnished to DDKS by Employer. However, in the case of an Enrollee in Continuation Coverage, such person shall be deemed to have enrolled when DDKS is timely furnished by the Enrollee with the applicable enrollment form and premium.

18. "Group Application" means the formal, written request for coverage by the Employer to DDKS. The Group Application includes all data and related information which is required to be provided to DDKS from time to time.

19. "Maximum Benefit" means the maximum benefit provided for Covered Services (and Orthodontic Services if specifically included as a Covered Service) which is set forth in the Summary of Dental Plan Benefits.

20. "Maximum Plan Allowance" means the lesser of the following:

    a. In the case of a Participating Delta Dental Premier Dentist:
       i) the fee submitted by the Participating Dentist for the Covered Service, or
       ii) the Delta Participating Dentist Maximum Plan Allowance for the Covered Service.

    b. In the case of a Delta Dental PPO Dentist:
       i) the fee submitted by the Delta Dental PPO Dentist for the Covered Service, or
       ii) the Delta Dental PPO Dentist Maximum Plan Allowance for the Covered Service.

    c. In the case of a Non-Participating Dentist:
       i) the fee submitted by the Dentist for the Covered Service,
       ii) the Delta Dental Non-Participating Dentist Maximum Plan Allowance, or
       iii) if this Plan utilizes an Exclusive Network, no benefits are provided.

21. "Orthodontic Services" means appliances and treatments, interceptive and corrective, whose purpose is to correct abnormally aligned or positioned teeth. X-rays, extractions and other dental services provided as part of the treatment of abnormally aligned or positioned teeth are considered "Orthodontic Services."

22. "Participating Dentist" means any Dentist who is a party to a valid Delta Dental Premier and/or PPO Participating Dentist Agreement with DDKS. These Dentist agree to render services in accordance with the terms and conditions established by DDKS and have satisfied DDKS that they are in compliance with such terms and conditions.

23. "Plan" means the dental benefits arrangement which is offered and administered pursuant to the terms of the Agreement.

24. "Spouse" means the Subscriber's spouse as determined under the laws of Kansas.

25. "Subscriber" means an Eligible Employee who has enrolled in the Plan during annual open enrollment or other enrollment period established by the Employer following the employee's hire date or the occurrence of a qualifying event, as described in the "Eligibility of Employees and Their Dependents" section, number 2.c., and timely payment of the required premium has been made.

EXCLUSIONS AND LIMITATIONS

1. Unless the "Summary of Dental Benefits" Section Specifically Provides For Coverage, The Following Dental Benefits And Services Are Excluded:

    a. Coverage for any patient who has been, but no longer is, an Enrollee.

b. Benefits or services for injuries or conditions compensable under Worker's Compensation or Employer's Liability laws; or benefits or services which are available from any Federal or State government agency, or similar entity.

c. Benefits, services, or appliances which are determined by DDKS to be for Cosmetic purposes.

d. Benefits, services or appliances, including but not limited to prosthodontics, including crowns and bridges, started prior to the date the person became an Enrollee.

e. Prescription drugs, premedication's and relative analgesia, including nitrous oxide; hospital, healthcare facility or medical emergency room charges; laboratory charges; anesthesia for restorative dentistry; preventive control programs.

f. Charges for failure to keep a scheduled visit; and charges for completion of forms.

g. Appliances or restorations for altering vertical dimension, for restoring occlusion, for replacing tooth structure lost by attrition, abrasion, bruxism, erosion, abfraction or corrosion; for splinting or equilibration.

h. Dental care injuries or disease caused by riots or any form of civil disobedience if the Enrollee was a participant therein; war or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer; injuries sustained while in the act of committing a criminal act; and injuries intentionally self-inflicted.

i. Temporary services and procedures, including, but not limited to, temporary prosthetic devices.

j. Any dental services, procedures, or products for which no benefit is provided, in whole or in part, under the terms of the Agreement.

k. Crowns and endodontic treatment in conjunction with an over denture.

l. Bridges and dentures, including repairs and adjustments, unless specifically included as a Covered Service in the "Summary of Dental Plan Benefits" section.

m. Replacement of lost or stolen dentures or charges for duplicate dentures.

n. Orthodontic Services and procedures related to Orthodontic Services, such as, but not limited to, x-rays, extractions, orthodontic appliance repairs and adjustments, unless Orthodontic Services are specifically included as a Covered Service in the "Summary of Dental Plan Benefits" section.

o. No benefits are payable for accidental bodily injuries arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used-including such benefits mandated by law) of any automobile policy.

p. Any benefit, procedure or service, to treat, modify, correct or change an existing condition or status caused or contributed to by prior medical or dental treatment, when prior treatment was performed in accordance with then generally accepted standards of medicine or dentistry in the local community where performed.

q. Dental benefits and services which are not completed.

r. Treatment rendered outside of the United States or Canada.

s. Services performed for the purpose of full mouth reconstruction are not Covered Services unless shown as a Covered Service in the "Summary of Dental Plan Benefits" section. For example, extensive treatment plans involving ten (10) or more crowns or units of fixed bridgework are considered full mouth reconstruction.

t. Benefits or services for control of harmful habits.

u. Procedures for dental implants and associated services, unless these are specified as Covered Services in the "Summary of Dental Plan Benefits" section.

v. Diagnosis or treatment of temporomandibular joint dysfunction, unless these are specified as Covered Services in the "Summary of Dental Plan Benefits" section.

2. Dental Benefits and Services are Limited as Follows, unless the "Summary of Dental Plan Benefits" section specifies other limitations. Typically, when dental benefits and services are limited under the Plan, any amounts not benefited by DDKS due to the limitation are the responsibility of the Enrollee, up to the amount of the Maximum Plan Allowance (MPA).

a. If a more expensive Covered Service is provided than DDKS determines to be the least costly professionally accepted treatment, DDKS will pay the applicable benefit for the Covered Service which is needed to achieve reasonable functionality.

b. Only the costs of the procedures necessary to prevent or eliminate oral disease and for appliances or restorations required to replace missing teeth are benefited by DDKS under the Plan and then only if specifically included as a Covered Service in the "Summary of Dental Plan Benefits" section.

c. Bitewings taken within twelve (12) months of a full mouth series of x-rays will be disallowed.

d. A panoramic film in conjunction with a full mouth services of x-rays is not a separate benefit.

e. A seven (7) vertical bitewing series is limited to once (1) every two (2) years.

f. Restoration of surfaces on teeth are limited to only once (1) or twice (2) within a twenty-four (24) month period dependent upon the anatomy of the tooth. Restorations on the same tooth done within twenty-four (24) months after a crown is seated are subject to frequency limitations.

g. Recementation of space maintainers are limited to once (1) per arch or quadrant per lifetime.

h. Inlays will automatically receive benefits equal to the corresponding surface of a filling.

i. Individual crowns are not a Covered Service unless specifically included as a Covered Service in the "Summary of Dental Plan Benefits" section. If a Covered Service:

(1) Individual crowns on the same tooth are limited to only once (1) in any five (5) year period unless needed because of injury. Said time period is to be measured from the date the crown was supplied to the Enrollee whether or not the Agreement was then effective. If a crown is placed on a tooth which has had a restoration in the previous twenty-four (24) month period, benefits paid for the crown are reduced by the benefit paid for the prior restoration.

(2) Porcelain crowns, porcelain fused to metal, or resin processed to metal type crowns are not benefited by DDKS for any person under twelve (12) years of age due to age limitation.

(3) Recementation of a crown is limited to only once (1) in a lifetime.

(4) Repairs per crown are limited to two (2) in a twelve (12) month period.

(5) Stainless steel crowns are limited to once (1) in a twenty-four (24) month period when placed on a primary tooth. If used as a permanent crown, the limitations of subparagraphs (1); (2); (3); and (4) of this subsection will apply.

(6) Core build-ups, including pins, are limited to permanent teeth having insufficient tooth structure to build a crown.

j. Prosthodontics are not a Covered Service unless specifically included as a Covered Service in the "Summary of Dental Plan Benefits" section. If a Covered Service, the following limitations apply unless the "Summary of Dental Plan Benefits" section states different limitations:

(1) Not more than one (1) full upper and one (1) full lower denture shall be constructed under the Agreement in any five (5) year period for any Enrollee. Said time period is to be measured from the date the denture was last supplied to the Enrollee whether or not the Agreement was then effective.

(2) A removable prosthetic or fixed prosthetic device, including bridges, or full upper or full lower dentures, may not be provided under the Agreement for any Enrollee more often than once (1) in any five (5) year period. Said time period is to be measured from the last date of service the removable prosthetic or fixed prosthetic device, including bridges, or full upper or full lower dentures was last supplied to the Enrollee whether or not the Agreement was then effective.

(3) Denture reline and rebase is limited to only once (1) in any thirty-six (36) month period for Enrollee.

(4) Denture adjustments are limited to only two (2) times in any twelve (12) month period for an Enrollee.

(5) Crowns when used for abutment purposes are benefited at the same co-payment percentage as provided under the Plan for bridges and complete and partial dentures.

(6) Recementation of a bridge is limited to only once (1) in a lifetime.

(7) If teeth are missing in both quadrants of the same arch, benefits are allowed for a bilateral partial toward the procedure submitted. If a fixed bridge or other more expensive procedure is selected, an allowance for a partial denture is made to restore the arch to contour and function.

(8) Only two (2) repairs per prosthesis, such as bridges, partials, or dentures, will be allowed in a twelve (12) month period.

(9) Tissue conditioning is limited to no more than two (2) per arch each thirty-six (36) months.

k. Endodontic procedures are not Covered Services unless specifically included as a Covered Service in the ”Summary of Dental Plan Benefits” section.

l. Periodontic procedures are not Covered Services unless specifically included as a Covered Service in the ”Summary of Dental Plan Benefits” section. When covered, payment is limited to only once (1) in any twenty-four (24) month period for all non-surgical periodontal procedures with the exception of the full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subject to the same limitations and is limited to one (1) per lifetime; periodontal maintenance which is limited to once (1) in any six (6) month period; and crown lengthening which carries no frequency limitation. For surgical periodontal

procedures, when covered, payment is limited to only once (1) in any thirty-six (36) month period.

m. Treatment to correct congenital or developmental malformations.

n. Payment for anesthesia and IV (intravenous) sedation is limited to only for surgical extractions which are Covered Services and is limited to a maximum of one (1) hour, per episode.

o. Orthodontic Services are not Covered Services unless specifically included as a Covered Service in the "Summary of Dental Plan Benefits" section. If a Covered Service:

(1) Plan benefits will cease on the date of termination if the treatment plan is terminated for any reason, or the Enrollee is no longer eligible for benefits before completion of the case. Treatment may be terminated by the Dentist, by written notification to DDKS and to the Enrollee, for lack of Enrollee interest and cooperation.

(2) Related services, such as but not limited to, x-rays, extractions, and study models, shall be payable at the orthodontic co-insurance percentage as specified in the "Summary of Dental Plan Benefits" section.

(3) The repair or replacement of an orthodontic appliance is not a Covered Service.

(4) Maximum Benefit for Orthodontic Services:

(a) Anything contained in the Agreement or any appendix to the contrary notwithstanding, the maximum benefit for Orthodontic Services payable in any one (1) contract Year, as applicable, or any portion thereof, shall be the amount indicated in the "Summary of Dental Plan Benefits" section.

(b) If Orthodontic Services are a Covered Service, payment for Orthodontic Services shall be limited to the Maximum Benefit per Enrollee which is specified in the "Summary of Plan Benefits" section. Payment for Orthodontic Services shall be made on a monthly basis as determined by the number of months of treatment established by the Dentist. Payment of initial fees may be made at the time of the treatment.

(c) If a Deductible applies, DDKS shall not be obligated to pay for, or otherwise discharge, in whole or in part, any fee, up to the Deductible.

(d) The Maximum Benefit for Orthodontic Services will be reduced by all amounts previously paid as orthodontics benefits by DDKS or by any other dental plan or arrangement.

(e) Rebonding, recementing and/or repair of fixed retainers must be included in the Orthodontics case fee. A separate fee submitted by the Orthodontics provider is not allowed. In cases of excessive or continuous repairs/recements/rebonds, individual consideration may be given to allow the service as a Covered Service.

3. **Certain dental benefits and services may be disallowed under the Plan. When dental benefits or services are disallowed, the fees associated with those items are neither benefited by DDKS nor collectable from the Enrollee by a Participating Dentist. Disallowed services will be so indicated on the applicable Enrollee's Explanation of Benefits.**

ELIGIBILITY OF EMPLOYEES AND THEIR DEPENDENTS

1. Eligible Employee:

To qualify as an Eligible Employee, an individual must meet one (1) of the following requirements:

a. Be an employee who is:

(1) Actively employed to work for Employer a regularly scheduled minimum twenty (20) hour per week or thirty (30) hour per week if a substitute teacher;

(2) On paid sick leave from such active employment;

(3) On any other approved leave of absence from such active employment; or

b. Be a former employee of Employer who is entitled to retirement benefits from Employer and meets all other requirements for coverage as determined by Employer.

c. Be a member in good standing of an organization, association or union which is the Employer, as determined under the rules of such organization, association or union.

d. Be a self-employed person who is actively engaged in a trade or business with at least one (1) other self-employed person or employee, all as determined by DDKS.

2. Commencement of Coverage for Employee:

a. With respect to a person who is an Eligible Employee on the Effective Date, coverage hereunder shall begin upon such person becoming a Subscriber.

b. With respect to a person who is not an Eligible Employee on the Effective Date, then coverage hereunder shall begin the first day of the month following the later of i) such person becoming a Subscriber, or ii) the effective date associated with the Employer designated enrollment period.

c. With respect to a person who is an Eligible Employee who experiences a "qualifying event", such Eligible Employee may make a new election within thirty-one (31) days of the qualifying event that corresponds to the gain or loss of eligibility and/or coverage under the Plan, or a plan of the Spouse's or Dependent's employer, that was caused by the occurrence of such qualifying event. Changes in coverage will become effective on the first day of the month coincident with or following the later of: i) the month in which the Eligible Employee becomes a Subscriber, ii) the effective date specified in the election, or iii) the submission of any required enrollment information and the payment of any required premium to DDKS. For purposes of the "Eligibility of Employees and Their Dependents" section, a "qualifying event" is any of the events described below:

(1) Legal Marital Status. A change in an Eligible Employee's legal marital status such as marriage or divorce.

(2) Number of Dependents. A change in the Eligible Employee's number of Dependents, including the birth and/or adoption of a child.

(3) Gaining or Losing Coverage Eligibility under another Employer's Plan. A change in coverage or eligibility status in which an Eligible Employee or Eligible Dependent gains or loses eligibility for coverage under a plan that is available to the Eligible Dependent. In such event an Eligible Employee may elect to cease or become covered under the Dependent's employer's plan.

3. No Coverage as Both Employee and Dependent:

No person may be insured both as an Eligible Employee and as an Eligible Dependent, and no person will be considered as an Eligible Dependent of more than one (1) Employee. Eligible Dependents do not include another Employee of the Employer who is insured under any employer-sponsored program providing dental expense coverage. A Child who may be otherwise eligible as a dependent under more than one (1) dental plan sponsored by the Employer, shall be covered under the plan of the Employee as explained in the "Non-Duplication of Benefits" section.

4. Commencement of Coverage for Dependent:

a. With respect to a person who is an Eligible Dependent on the Effective Date, coverage hereunder shall begin for such Eligible Dependent upon the later of i) the first day that the coverage commences for the Subscriber, or ii) the date such person satisfies the requirements to become an Enrollee.

b. With respect to a person who is an Eligible Dependent who is not an Enrollee on the Effective Date, if the Employer elects annual open enrollment, then coverage hereunder shall begin upon the later of i) the Subscriber with respect to whom such person is a dependent becoming a Subscriber, ii) the date upon which such person satisfies the requirements to become an Enrollee, or iii) upon the effective date associated with such open enrollment period.

c. With respect to a person who becomes an Eligible Dependent and therefore qualifies for coverage as a result of a qualifying event, then coverage hereunder shall begin upon the first day of the month coincident with or following the later of i) the Subscriber with respect to whom such person is a dependent becoming a Subscriber, ii) the date upon which such person satisfies the requirements to become an Enrollee.

5. Termination of Benefits:

a. If, at any time, a Subscriber fails to satisfy all of the requirements of the Agreement, coverage under the Agreement shall terminate for such Subscriber, and each dependent of such Subscriber, in the following manner:

1) If the Subscriber qualifies for, timely elects and timely pays for Continuation Coverage, then the Subscriber shall continue to be covered for the applicable period during which coverage must be provided and during which premiums are timely paid, and thereafter coverage shall terminate;

2) If the Subscriber fails to qualify for, timely elect or timely pay for Continuation Coverage, then coverage shall terminate at the end of the premium period in which the Subscriber first ceases to satisfy such requirements.

b. If, at any time, an Enrollee who is not the Subscriber ceases to qualify as Eligible Dependent, coverage under the Agreement shall terminate:

1) If the Enrollee qualifies for, timely elects, and timely pays for Continuation Coverage, then the Enrollee shall continue to be covered for the applicable period during which coverage must be provided and during which premiums are timely paid, and thereafter the coverage shall terminate;

2) If the Enrollee fails to qualify for, timely elect, or timely pay for Continuation Coverage, then coverage shall terminate at the end of premium period in which the Subscriber upon whom such person is dependent ceases to constitute a Subscriber, or at the time such dependent ceases to qualify as an Eligible Dependent, whichever occurs first.

d. At termination of coverage under the Agreement, operative procedures which are then in progress and i) which are completed within thirty (30) days of the termination of coverage, and ii) submitted for payment within six (6) months of such termination shall be covered. For this purpose, operative procedures are

defined as and limited to root canal therapy on permanent teeth; individual crowns; dentures, partial and complete; and bridges. Operative procedures are considered in progress only if all procedures for commencement of lab work have been completed.

6. Non-Duplication of Benefits:

A. GENERAL.

This section entitled Non-Duplication of Benefits addresses coordination of benefits (COB) and applies when a person has dental care coverage under more than one plan. The term "plan" is defined below. The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

B. DEFINITIONS.

(1) A "plan" is any of the following that provides benefits or services for dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(a) The term "plan" includes group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.

(b) The term "plan" does not include individual or family insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of $200 or less per day; school accident type coverage, benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies, and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under (a) or (b) is a separate plan. If a plan has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is treated as a separate plan.

(1) The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.

When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

(3) "Allowable expense" means a dental care service or expense, including deductibles and co-payments, or co-insurance that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

(a) If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.

(b) The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions. Examples of these provisions are second opinions, precertification requirements, and preferred provider arrangements.

(4) "Claim determination period" means a contract year. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.

(5) "Closed panel plan" is a plan that provides dental benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

(6) "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

C. ORDER OF BENEFIT DETERMINATION RULES.

When two (2) or more plans pay benefits, the rules for determining the order of payment are as follows:

(1) The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

(2) A plan that does not contain a coordination of benefits, maintenance of benefits, or non-duplication of benefits provision that is consistent with the "Non-Duplication of Benefits" section is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(3) A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

(4) The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

(a) The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two (2) plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

(b) The order of benefits when a child is covered by more than one plan is:

1. The primary plan is the plan of the parent whose birthday is earlier in the year if:

a. The parents are married;

b. The parents are not separated (whether or not they ever have been married); or

c. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

e. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

2. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those

terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

3. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

   a. The plan of the custodial parent;

   b. The plan of the spouse of the custodial parent;

   c. The plan of the noncustodial parent; and then

   d. The plan of the spouse of the noncustodial parent.

(c) The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an 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 is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the order described in the "C. Order of Benefit Determination Rules 4(a)."

(d) If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. 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 is ignored.

(e) The plan that covered the person as an employee, member, subscriber or retiree longer is primary.

(f) If a health plan includes coverage for dental procedures under the major medical provisions of the plan, that plan is primary.

(g) If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

D. EFFECT ON THE BENEFITS OF THIS PLAN.

(1) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than one hundred percent (100%) of total allowable expenses.

The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:

(a) Determine its obligation to pay or provide benefits under its contract;

(b) Determine whether a benefit reserve has been recorded for the covered person; and

(c) Determine whether there are any unpaid allowable expenses during that claims determination period.

If there is a benefit reserve, the secondary plan will use the covered person's benefit reserve to pay up to one hundred percent (100%) of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

(2) If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts about coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. DDKS may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. DDKS need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give DDKS any facts it needs to apply those rules and determine benefits payable.

F. FACILITY OF PAYMENT.

A payment made under another plan may include an amount that should have been paid under this plan. If it does, DDKS may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. DDKS will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

G. RIGHT OF RECOVERY.

If the amount of the payments made by DDKS is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

DELTA DENTAL OF KANSAS
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions concerning this notice, please contact:
Privacy Officer
Delta Dental of Kansas
P.O. Box 789769
Wichita, KS 67278-9769
(316) 264-1099 or (800) 733-5823

Delta Dental of Kansas, Inc. (the "Plan") is required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information and we are committed to protecting the privacy and confidentiality of your health and personal information.

HOW THE PLAN MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Uses and Disclosures of Protected Health Information Without Your Specific Authorization

The Plan may use and disclose your health information about you for payment or health care operations without any consent or authorization beyond your enrollment in the Plan.

Payment means activities related to the Plan's payment to pay you or your health care provider for covered expenses. Activities associated with payment include, but are not limited to, enrollment activities; collection of contributions from you and your employer; payment for covered expenses, including coordination of benefits; review of payment decisions upon appeal; activities related to pre-authorization of benefits and utilization review; and disclosure of contribution payment history to a consumer reporting agency.

Health Care Operations means activities undertaken to administer your program including, but not limited to, activities necessary to reduce overall health care costs; contacting you or your health care provider about alternative treatments; evaluating practitioner and provider performance; training of non-health care professionals; activities related to obtaining an insurance contract, such as census rating for premiums; conducting or arranging for claims review, legal services, and auditing functions; fraud and abuse detection and compliance-related activities; analysis related to managing and operating the Plan; development or change of payment methods or coverage policies; and educational activities.

Under applicable federal law, there are other uses and disclosures the Plan may make without your specific authorization some are included below:

Disclosures of Protected Health Information to the Plan Sponsor. The Plan will disclose protected information only to the minimal extent it helps your employer administer the program, such as providing billing information, and confirmation of enrollment. The employer must limit its use of that information to obtaining quotes or modifying, amending, or terminating the Plan.

Creation of de-identified health information. The Plan may use your protected health information to create de-identified health information. This means that all data items that would help identify you, such as name, address, birth date, and hire date are removed or modified. Once information is de-identified it is no longer protected.

Furnishing data to Business Associates. The Plan's Business Associates (e.g., printers, mailing services, legal counsel, and consultants) receive and maintain your protected health information to carry out payment and health care operations.

Uses and disclosures required by law. The Plan will use and/or disclose your protected health information when required by law to do so. The disclosure will be the minimum necessary to fulfill the legal requirement.

Disclosures for public health activities. We may disclose your protected health information for the following public health activities in circumstances that would help prevent or control disease, report child abuse, and domestic violence. Such disclosure will be made only to extent required by law or with your agreement.

Disclosures for health oversight activities. The Plan may disclose your protected health information to a health oversight agency for oversight activities to complete applicable audits, investigations or inspections.

Disclosures for judicial and administrative proceedings. Your protected health information may be disclosed during any judicial or administrative proceeding as required by appropriate administrative or judicial court proceedings.

Disclosures for law enforcement purposes. We may disclose your protected health information to a law enforcement official as required by law or to comply with a court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer.

Disclosures regarding victims of a crime or to avert a serious threat to health or safety. In response to a law enforcement official's request, the Plan may disclose information about you with your approval or in an emergency situation and you are incapacitated, or if it appears you were the victim of a crime. We may also disclose your protected health information to prevent or lessen a serious and imminent threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

Disclosures for specialized government functions. The Plan may disclose your protected health information as required to comply with governmental requirements for national security reasons or for protection of certain government personnel or foreign dignitaries.

Fundraising. We may send you information as part of our fundraising activities. You have the right to opt out of receiving this type of communication.

Other Uses and Disclosures Requiring Your Authorization. All other uses and disclosures of your health information, including family members or any other individual not already authorized to receive protected health information, will be made by the Plan only with your express written authorization.

Furthermore, while the Plan does not typically use or disclose your protected health information for marketing purposes; sell your protected health information for direct or indirect financial benefit or non-financial benefit (i.e. in-kind item or service); or retain, use or disclose psychotherapy notes, if the Plan does intend to engage in such activity, your authorization will be obtained as required by law prior to engaging in said activity.

If you provide authorization for any use or disclosure of your protected health information, you may revoke that authorization, in writing, at any time. The revocation will not apply to any previous use or disclosure.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right To Inspect and Copy. You have the right to inspect and copy health information collected and maintained by the Plan. To inspect and copy your health information, you must complete a specific form providing information needed to process your request from the Privacy Officer at the address identified on this Notice. You may request that your health information be provided in an electronic form and we can work together to agree on an appropriate electronic format. You may be charged a fee to cover expenses associated with your request. We can refuse access under certain circumstances. If the Plan refuses access, you will be notified in writing and may be entitled to have a neutral person review the refusal.

Right To Amend Incorrect or Incomplete Information. You may request that Plan change your health information, although we are not required to do so. If your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make your request in writing. You must also provide a reason for your request.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you, with certain exceptions specifically defined by law. To request this list or accounting of disclosures, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice.

Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request restrictions, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice.

We are not required to agree to your request for restrictions. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Right to Request Alternative Methods of Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request an alternative method of communications, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the person identified on the first page of this Notice. You may obtain a copy of this notice at our website, http://www.deltadentalks.com.

Right to Breach Notification. You have the right to be notified if we determine that there has been a breach of your protected health information.

COMPLAINTS

If you believe your rights with respect to health information about you have been violated by the Plan, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the person identified on the first page of this Notice. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

The effective date of this Notice is September 23, 2013. The Plan reserve the right to change the terms of this notice and to make the revised notice effective with respect to all protected health information regardless of when the information was created. If the notice is revised, the new notice will be provided to you, if you are still covered by the Plan, either through e-mail or U.S. postal service, within sixty days of such revision. Otherwise, we will provide you once every three years a reminder of the availability of this Notice and how to obtain the Notice.

Welcome to Delta Dental of Kansas, Inc.

Delta Dental of Kansas, Inc. is a member of Delta Dental Plans Association, the leading and largest underwriter of group dental coverage in the United States. Together with your employer, we have designed a dental benefit plan to help protect the oral health of you and your covered dependents. Regular preventive dental care not only reduces the cost and the pain generally associated with extensive dental work, but a healthy mouth contributes to the overall well-being of every person.

You are free to go to any dentist of your choosing; however, there may be a difference in payment if the dentist is not a participating dentist with Delta Dental. Since over 75% of the dentists do contract with Delta Dental, the chances are excellent your dentist is already a member. If you have any questions about whether your dentist participates with Delta Dental, ask your dentist when making an appointment or contact the Customer Service staff at Delta Dental of Kansas, Inc. by calling (316) 264-4511 or toll free (800) 234-3375. You may also access our network, nationwide, through our website at www.deltadentalks.com.

From our website, you can

- Check your eligibility and plan information
- Print yourself an ID card
- Check claim status
- Locate a participating **Delta Dental Premier** dentist
- Learn about oral health and wellness
- Use our flexible spending account estimator

It is our pleasure to be of service to you.

Summary of Dental Plan Benefits

U S D #262 - VALLEY CTR-LOW

Group #52109-000-00001-00000

% paid by Plan				Examples of Covered Services
DIAGNOSTIC & PREVENTIVE (Not subject to Deductible)				
PPO Network	**Premier Network**	**Non Network**		
100%	**100%**	**100%**	**I.**	**DIAGNOSTIC**: Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: Oral evaluations – two (2) times per Contract year. Bitewing x-rays – bitewings two (2) times per Contract year for dependents under age eighteen (18) and once (1) each twelve (12) months for adults age eighteen (18) and over. Full mouth or panoramic x-rays – once (1) each five (5) years.
100%	**100%**	**100%**	**II.**	**PREVENTIVE:** Provides for the following: Prophylaxis (Cleanings) – two (2) times per Contract year. Topical Fluoride – two (2) times per Contract year for dependent children under age nineteen (19). Space Maintainers for dependent children under age fourteen (14) and only for premature loss of primary molars. Sealants – once (1) per tooth per lifetime for dependent children under age sixteen (16) when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.
BASIC (Subject to Deductible)				
50%	**50%**	**50%**	**III.**	**ANCILLARY:** Provides for one (1) emergency examination per Plan year by the Dentist for the relief of pain.
50%	**50%**	**50%**	**IV.**	**ORAL SURGERY:** Provides for simple extractions only.
50%	**50%**	**50%**	**V.**	**REGULAR RESTORATIVE DENTISTRY**: Provides amalgam (silver) restorations, composite (white) resin restorations; and stainless steel crowns for dependents under age twelve (12).

% paid by Plan				Examples of Covered Services
BASIC (continued) (Subject to Deductible)				
PPO Network	**Premier Network**	**Non Network**		
50%	**50%**	**50%**	**VI.**	**PERIODONTICS:** Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is counted toward the frequency limitation for prophylaxis cleanings.
MAJOR (Subject to Deductible)				
None	**None**	**None**	**VII.**	**ORAL SURGERY:** Provides for surgical extractions (excluding simple extractions) and other oral surgery including pre and post-operative care.
None	**None**	**None**	**VIII.**	**ENDODONTICS**: Includes procedures for root canal treatments and root canal fillings. When covered, payment for root canal therapy is limited to only once (1) in any twenty-four (24) month period, per tooth.
None	**None**	**None**	**IX.**	**PERIODONTICS:** Surgical periodontal procedures.
None	**None**	**None**	**X.**	**SPECIAL RESTORATIVE DENTISTRY:** When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
			XI.	**PROSTHODONTICS**:
None	**None**	**None**	a.	Includes bridges, partial and complete dentures.
None	**None**	**None**	b.	Repairs and adjustments of bridges and dentures.
ORTHODONTICS (Subject to Deductible)				
None	**None**	**None**	**XII.**	**ORTHODONTICS**: Orthodontic appliances and treatment.

A Covered Service is deemed to be benefited by DDKS if it is reimbursable, in whole or in part, under the terms of the Plan or would otherwise be reimbursable, in whole or in part, except for the application of a deductible, co-insurance payment, waiting period, frequency limitation, annual or lifetime benefit maximum, or other limitation contained in the Plan. For a Covered Service benefited by DDKS through payment, DDKS will pay the lesser of i) the percentage of the fee actually charged for a Covered Service which is indicated in the Summary of Dental Plan Benefits, or ii) in the amount which is otherwise pay in accordance with other provisions of the Plan.

This is a Summary of Benefits only, and various exceptions and limitations may apply. Your actual coverage is described in the Agreement which is binding on all of the parties and supersedes all other written or oral communications.

SEE SECTION ON EXCLUSIONS AND LIMITATIONS FOR ADDITIONAL INFORMATION

Selected Network
The Dental Networks for this Agreement are Delta Dental Premier and PPO.

Maximum Benefit(s) Per Person
Regular Services:
The Maximum Benefit for all Covered Services for each Enrollee in any one contract Year is One Thousand Dollars ($1000.00).

Deductible Limitations
Coverage for Diagnostic and Preventive Services is not subject to the Deductible. However, the Deductible shall apply during each contract Year to all other Covered Services which are provided to each Enrollee.

After Enrollees have, in any contract Year, each paid either the individual Deductible of Fifty Dollars ($50.00), or have cumulatively paid charges for Covered Services in the amount of One Hundred Fifty Dollars ($150.00), the deductible requirements of the preceding sentence shall no longer be applicable for any Covered Services during the remaining portion of that contract Year.

Payment of Claims
Before paying claims, DDKS may require reasonable evidence of the payment of Deductibles.

Eligible Children Ages
Children are eligible for coverage to age 26.

DESCRIPTION OF DENTAL CARE COVERAGE

This Description of Dental Care Coverage is issued to the Subscriber by Delta Dental of Kansas, Inc., hereinafter referred to as "DDKS", a nonprofit dental service corporation incorporated under the laws of Kansas.

This document is intended to be an easy-to-read outline of the principal features of your dental coverage program and constitutes your summary of the Agreement and contains the provisions of your dental coverage. The Agreement between your Employer and DDKS is the controlling document for all benefits, terms and conditions and supersedes all other written or verbal communications regarding the Plan. Only the cost of dental procedures necessary to eliminate oral disease or for appliances or restorations required to replace missing teeth are benefits under the Agreement and then only if identified as a covered dental benefit in the "Summary of Dental Plan Benefits" section. Certain restrictions may be applicable to your coverage. It is important to review the "Exclusions and Limitations" section of this document for these conditions.

If any state or federal legislation or regulation is in effect, enacted, or amended mandating a change in the dental benefits described in this booklet, appropriate modifications will be made in the benefits provided under the Agreement.

HOW TO USE YOUR PLAN

Make an appointment with your Dentist. Tell the Dentist that you are covered by Delta Dental of Kansas, Inc.

If the planned treatment involves prosthodontic or orthodontic procedures, individual crowns (except stainless steel), gold restorations, surgical periodontics, endodontics or oral surgery, except for simple extraction of a single tooth, the Dentist should submit a treatment plan to DDKS to determine how much of the bill will be paid by DDKS and what your share of the cost will be. Failure by your Dentist to predetermine benefits may result in a higher cost to you than anticipated if, in the professional judgment of DDKS's consultant, the treatment is not necessary or a lesser procedure could have restored the tooth to contour and function. Even if the Dentist does predetermine benefits, however, it does not obligate DDKS if you as an employee or dependent are no longer eligible for benefits at the time the services are actually performed or your Dentist was not a Participating Dentist with Delta Dental at the time services were performed. The treatment must commence within ninety (90) days of the date the treatment plan is submitted to DDKS by the treating Dentist or a new treatment plan should be obtained and resubmitted to DDKS.

PAYMENTS FOR COVERED SERVICES

Following treatment, the Dentist should forward the attending Dentist's statement to DDKS. If the Dentist is a Participating Dentist, DDKS will make direct payment to the Dentist for each Covered Service. If the Dentist is not a Participating Dentist, DDKS will pay the Employee on each Covered Service. The amount of payment will be calculated using the percentage amount indicated in the "Summary of Dental Plan Benefits" section

in this booklet. If more than one percentage column is shown in the Summary of Dental Plan Benefits, the percentage used will be the one that corresponds to the network status of the Dentist at the time the Covered Services are rendered. DDKS will pay for each Covered Service, subject to the Coordination of Benefits (COB) stipulations in the "Non-Duplication of Benefits" section of this booklet, based on the lesser of i) the fee submitted by the Dentist for the Covered Service, or ii) the Maximum Plan Allowance (MPA). For more information on MPA, see the definition of MPA in the "Definitions" section of this booklet.

You will receive notice of the Plan's payment and the amount, if any, that you owe the Dentist. The amount you owe should be paid in accordance with the Dentist's usual billing procedure.

NO PRE-EXAMINATION

There are no pre-examination requirements for employees and dependents to be eligible for dental benefits.

EMERGENCY TREATMENT

Each individual dental office has its own emergency treatment protocol and Enrollees should contact their Dentist and familiarize themselves with the procedure for emergencies that occur outside the Dentist's normal business hours. Hospital or medical service emergency room expenses are <u>not</u> covered benefits under the Plan.

INQUIRIES/APPEALS

Enrollees are encouraged to contact DDKS when they have a question concerning a particular claim. Such inquiry should be directed to the DDKS Customer Service Department. Telephone inquiries may be directed to the following numbers: in Wichita, 316-264-4511 or from outside of the Wichita area, 1-800-234-3375.

If a claim for benefits is denied in whole or in part, written notification called an "Explanation of Benefits" will be provided within thirty (30) days after a claim is received, unless special circumstances require an extension of time for processing. If additional time is necessary, DDKS will notify the Enrollee and/or the treating dentist of the reason for the additional time, including a description of additional information that is necessary to process the claim if information is missing. If additional information is necessary, the Enrollee will have forty-five (45) days to provide the additional information or else the claim will be decided based upon the information then available to DDKS.

Enrollees have the right to appeal a claim determination if the requested dental benefits were not paid in full. In order to appeal a benefit determination, Enrollees or their authorized representative must write to the Customer Service Department, Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, KS 67278-9769 within one hundred eighty (180) days of the date of the Explanation of Benefits for the claim. Written appeals

should be submitted with a copy of the Explanation of Benefits form for the claim in question and should include all of the following:

1. Employer group number and member identification number.
2. Subscriber's name and birth date. If the Enrollee is not the Subscriber, the Enrollee's name and birth date must also be included.
3. Dentist name and, if known, license number.
4. Claim number.
5. Date(s) of service.
6. An explanation of the complaint or question, including the basis for appeal.
7. Any additional information that the Enrollee believes supports his/her position.

A full and fair evaluation of the appeal will be made by DDKS and, in some cases the Enrollee may be examined clinically. If necessary, additional information or documents may be requested. Some matters may also be referred to the dental licensing board or to the applicable state dental association peer review system.

Normally, Enrollees will receive a written acknowledgement of their inquiry or appeal within twenty (20) days of DDKS' receipt. However, if the matter is referred to a review committee, or other unusual circumstances arise, the Enrollee will be advised. Generally, a written answer or decision will be sent to the Enrollee within thirty (30) days thereafter, however, DDKS must provide a written answer or decision within sixty (60) days receipt of the appeal.

If DDKS denies any part of the claim on appeal, DDKS will provide the Enrollee written notice of the basis for the denial and additional information. The Enrollee may request, free of charge, a copy of any applicable rules, exclusions, or limitations relied upon in the benefit determination. In addition, DDKS will provide the Enrollee with a copy of the documents relevant to the benefit determination free of charge upon request.

If the dental plan at issue is governed by the Employee Retirement Income Security Act, an Enrollee may have the right to bring a civil action under Section 502(a). In addition, an Enrollee may be entitled to additional levels of review and/or other voluntary alternative dispute resolution options, such as mediation under his/her group dental plan.

REEVALUATION AND REVIEW

If the Employer or Enrollee does not agree with the determination of benefits and has additional information to supply, reevaluation may be requested by resubmitting a copy of the claim form, x-rays and clinical comments to the Customer Service Department, Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, Kansas 67278-9769. The review of a claim form and x-rays may not be sufficient to appropriately resolve a matter in all cases. Accordingly, in some cases DDKS may rely on its regional dental consultants to examine patients clinically. When appropriate, examinations may also be conducted at the request of the Enrollee, a treating Dentist, or for other reasons determined by DDKS.

DDKS LIABILITY

DDKS shall have no liability for any wrongful conduct of any third party, including but not limited to tortuous conduct, negligence, wrongful acts or omissions, or any other act of any such person including but not limited to employees, Enrollees, Dentists, dental assistants, dental hygienists, hospitals, or the agents or employees of any of such foregoing persons, whether receiving or providing services. Further, DDKS shall also have no liability for any services or facilities which, for any reason, are unavailable to any Enrollee.

RIGHT TO INFORMATION

As a condition precedent to the approval of claims hereunder, DDKS, shall be entitled to receive from any attending or examining Dentist, or from hospitals or clinics in which a Dentist's care is rendered, such information and records relating to attendance to, or examination of, and/or treatment rendered to, an Enrollee. DDKS, at its own expense, shall have the right to cause any Enrollee to be examined when and so often as DDKS reasonably deems necessary during the pendency of a claim under the Agreement (including the right and opportunity to make an autopsy if it is not prohibited by law). The acceptance by any Enrollee of any benefit of coverage under the Agreement constitutes the Enrollee's (and the related Subscriber's, if applicable) automatic and irrevocable consent to the release to DDKS of any and all of the information and records before described, and a full waiver by that Enrollee that any such information and records that otherwise is privileged. Further, by providing Covered Services to an Enrollee, a Dentist or other service provider consents to, upon request, provide such information and records to DDKS as DDKS requests.

MISREPRESENTATIONS

No statements made by the Employer, or any other person, shall be deemed a warranty or shall be used in defense of a claim or in any other dispute under the Agreement, unless it is contained in a written instrument, a copy of which has been agreed to in writing by Employer and DDKS.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the Agreement prior to the expiration of sixty (60) days after the final written notice determining the status of a claim for breach has been delivered in accordance with the requirements of the Agreement. Further, and in all events, any action of any kind by any person who is subject to the Agreement must be commenced within five (5) years from the date on which the right, claim, demand, or cause of action shall first accrue.

GOVERNING STATUTES

Any provision of the Agreement which is in conflict with any applicable law is hereby amended to the minimum requirements of such law.

GOVERNING LAW

Except to the extent preempted by the Employee Retirement Income Security Act of 1974 (ERISA), the laws of the State of Kansas (irrespective of choice of law principles) shall govern the validity of the Agreement, the construction of its terms and the interpretation of the rights and duties of the parties. Any action brought to enforce, construe, or interpret the Agreement (including but not limited to any mediation or arbitration but only if arbitration is voluntarily agreed to by the parties at the time a dispute arises) shall be commenced and maintained in a location mutually agreeable by the parties to the dispute. Except to the extent preempted by ERISA, the parties irrevocably consent to the exclusive jurisdiction and venue in the court mutually agreed to by the parties for such purpose and agree not to seek transfer or removal of any action commenced in connection with the Agreement.

DEFINITIONS

For the purpose of this Description of Dental Care Coverage, the following definitions shall apply:

1. "Agreement" means the agreement between DDKS and Employer, including the Group Application, the attached appendices, endorsements and riders, if any. The Agreement constitutes the entire agreement between the parties.

2. "Benefit Booklet" means this written summary of certain features of the Plan.

3. "Child" or "Children" means, in addition to the Subscriber's own or lawfully adopted unmarried child or children, any unmarried step-child of the Subscriber residing with the Subscriber in a regular parent-child relationship so long as said child is not eligible to enroll in an "eligible employer-sponsored health plan" as defined by federal law. The term "Child" also includes any unmarried person placed with the Subscriber for adoption if such child was placed in the Subscriber's home by a child placement agency as defined by Kansas law, and any unmarried child of the Subscriber who is recognized as an alternate recipient under a qualified medical child support order. A child is eligible for coverage under the Plan if the child meets the age requirements as set forth in the "Eligible Children Ages" section.

   In addition, a Child includes an unmarried disabled Child who is: i) incapable of earning his or her own living because of mental or physical disability, and ii) principally dependent upon the Subscriber for support at the time the Child would otherwise cease to be eligible for coverage by the Plan because of age. A disabled Child shall continue to be an Eligible Dependent for the duration of the disability, provided: i) his or her status as an Eligible Dependent does not terminate for any other reason, and ii) proof of disability is furnished to DDKS within thirty-one (31) days after Child attains the age which would otherwise be disqualifying. Such proof of disability must thereafter be furnished from time to time as required by DDKS.

4. "Continuation Coverage" means the coverage provided under the Agreement pursuant to Section 4980B of the Internal Revenue Code of 1986, as amended

("Code"). All of the requirements, definitions and specifications of said Section 4980B of the Code which are necessary in order for the Agreement to satisfy Section 4980B of the Code, are being hereby adopted and incorporated by reference.

5. "Contract Year" means the period commencing on the Effective Date and terminating at 11:59 P.M. on the day preceding the anniversary thereof.

6. "Calendar Year" means the twelve (12) month period commencing on the first day of January and terminating at 11:59 P.M. on the last day of December.

7. "Cosmetic" means those services provided by Dentists for the purpose of improving the oral appearance when form and function are otherwise satisfactory. The determination of whether services are "Cosmetic" shall be made by DDKS in its discretion. Cosmetic services are not Covered Services under the Plan unless a Cosmetic service is specified as a Covered Service in the "Summary of Dental Plan Benefits" section.

8. "Covered Services" means those dental services, procedures, and products that are benefitted by DDKS, in whole or in part, pursuant to the terms of the Plan.

9. "DDKS" means Delta Dental of Kansas, Inc., which shall be the control plan, or any other Delta Dental Plans Association member company which has agreed to provide to Enrollees the benefits described in the Agreement, or both, as applicable.

10. **"**Deductible" means the amount specified in the "Summary of Dental Plan Benefits" section which must be paid with respect to Covered Services provided to an Enrollee before the Plan provides benefits.

11. "Dental Network" means one of the following networks as identified in the "Summary of Dental Plan Benefits" section:

    a.1. "**Delta Dental Premier":** The Delta Dental Premier network is a traditional fee-for-service network, and is the broadest network of Dentists that DDKS offers. All Delta Dental Premier providers are considered Participating Dentists and are paid according to DDKS' Participating Dentist Maximum Plan Allowance (MPA) as defined below. Non-Participating Dentists are <u>not</u> considered Delta Dental Premier Providers, and are paid according to DDKS' Non-Participating Dentist Maximum Plan Allowance.

    2. If Delta Dental Premier is the Exclusive Network, then Enrollees must exclusively use Dentists in the Delta Dental Premier network in order to receive the benefits provided by the Plan. If an Enrollee chooses a Dentist who does not participate in the Delta Dental Premier network, the Enrollee is responsible for <u>all</u> treatment costs incurred.

    b.1. **"Delta Dental PPO":** The Delta Dental PPO network is a subset of DDKS Participating Dentists who agree contractually to participate in the Delta Dental PPO network as part of a discounted fee-for-service plan. Delta

Dental PPO providers sign a supplemental agreement and are paid according to a Maximum Plan Allowance for PPO Dentists as defined below. Delta Dental PPO Dentists are paid at the in-network co-insurance percentages in the "Summary of Dental Plan Benefits" section, while Delta Dental Premier Dentists and non-participating Dentists are paid at the out-of-network co-insurance percentages in the "Summary of Dental Plan Benefits" section.

2. If Delta Dental PPO is the Exclusive Network, then Enrollees in the plan must exclusively use Dentists in the Delta Dental PPO network in order to receive the benefits provided by the Plan. If an Enrollee chooses a Dentist who is not a Delta Dental PPO Dentist, the Enrollee is responsible for all treatment costs incurred.

12. "Dentist" means any duly licensed dentist entitled to practice dentistry at the time and in the place the dental services are performed.

13. "Effective Date" means the first day of the initial term of the Agreement.

14. "Eligible Dependent" means i) the opposite sex spouse, as determined under applicable state law at the time and location that the marriage was entered into, ii) a Child of an Eligible Employee who satisfies the requirements of the definition of "Child" in Number 3 of this section of this booklet, and iii) any such spouse or Child who timely elects Continuation Coverage and for whom the appropriate premium is timely received by DDKS.

15. "Eligible Employee" means any person who meets the conditions of eligibility outlined in "Eligibility of Employees and Their Dependents" section, and any person who no longer meets such conditions but who timely elects Continuation Coverage and for whom the appropriate premium is timely received by DDKS.

16. "Employer" means the person(s) and/or entity(ies) named above which has hereby contracted with DDKS to provide the Plan described in the Agreement, and such members of the Employer's controlled or affiliated group which are specifically listed in the Group Application.

17. "Enrollee" means a person, whether an Eligible Employee or Eligible Dependent, who is i) eligible to be covered by the Plan, ii) validly enrolled in the Plan, and iii) for whom the appropriate premium is timely received by DDKS. An Enrollee shall be deemed to have enrolled when such Enrollee's name, enrollment information and the required premium are furnished to DDKS by Employer. However, in the case of an Enrollee in Continuation Coverage, such person shall be deemed to have enrolled when DDKS is timely furnished by the Enrollee with the applicable enrollment form and premium.

18. "Group Application" means the formal, written request for coverage by the Employer to DDKS. The Group Application includes all data and related information which is required to be provided to DDKS from time to time.

19. "Maximum Benefit" means the maximum benefit provided for Covered Services (and Orthodontic Services if specifically included as a Covered Service) which is set forth in the Summary of Dental Plan Benefits.

20. "Maximum Plan Allowance" means the lesser of the following:

    a. In the case of a Participating Delta Dental Premier Dentist:
       i) the fee submitted by the Participating Dentist for the Covered Service, or
       ii) the Delta Participating Dentist Maximum Plan Allowance for the Covered Service.

    b. In the case of a Delta Dental PPO Dentist:
       i) the fee submitted by the Delta Dental PPO Dentist for the Covered Service, or
       ii) the Delta Dental PPO Dentist Maximum Plan Allowance for the Covered Service.

    c. In the case of a Non-Participating Dentist:
       i) the fee submitted by the Dentist for the Covered Service,
       ii) the Delta Dental Non-Participating Dentist Maximum Plan Allowance, or
       iii) if this Plan utilizes an Exclusive Network, no benefits are provided.

21. "Orthodontic Services" means appliances and treatments, interceptive and corrective, whose purpose is to correct abnormally aligned or positioned teeth. X-rays, extractions and other dental services provided as part of the treatment of abnormally aligned or positioned teeth are considered "Orthodontic Services."

22. "Participating Dentist" means any Dentist who is a party to a valid Delta Dental Premier and/or PPO Participating Dentist Agreement with DDKS. These Dentist agree to render services in accordance with the terms and conditions established by DDKS and have satisfied DDKS that they are in compliance with such terms and conditions.

23. "Plan" means the dental benefits arrangement which is offered and administered pursuant to the terms of the Agreement.

24. "Spouse" means the Subscriber's spouse as determined under the laws of Kansas.

25. "Subscriber" means an Eligible Employee who has enrolled in the Plan during annual open enrollment or other enrollment period established by the Employer following the employee's hire date or the occurrence of a qualifying event, as described in the "Eligibility of Employees and Their Dependents" section, number 2.c., and timely payment of the required premium has been made.

EXCLUSIONS AND LIMITATIONS

1. Unless the "Summary of Dental Benefits" Section Specifically Provides For Coverage, The Following Dental Benefits And Services Are Excluded:

    a. Coverage for any patient who has been, but no longer is, an Enrollee.

b. Benefits or services for injuries or conditions compensable under Worker's Compensation or Employer's Liability laws; or benefits or services which are available from any Federal or State government agency, or similar entity.

c. Benefits, services, or appliances which are determined by DDKS to be for Cosmetic purposes.

d. Benefits, services or appliances, including but not limited to prosthodontics, including crowns and bridges, started prior to the date the person became an Enrollee.

e. Prescription drugs, premedication's and relative analgesia, including nitrous oxide; hospital, healthcare facility or medical emergency room charges; laboratory charges; anesthesia for restorative dentistry; preventive control programs.

f. Charges for failure to keep a scheduled visit; and charges for completion of forms.

g. Appliances or restorations for altering vertical dimension, for restoring occlusion, for replacing tooth structure lost by attrition, abrasion, bruxism, erosion, abfraction or corrosion; for splinting or equilibration.

h. Dental care injuries or disease caused by riots or any form of civil disobedience if the Enrollee was a participant therein; war or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer; injuries sustained while in the act of committing a criminal act; and injuries intentionally self-inflicted.

i. Temporary services and procedures, including, but not limited to, temporary prosthetic devices.

j. Any dental services, procedures, or products for which no benefit is provided, in whole or in part, under the terms of the Agreement.

k. Crowns and endodontic treatment in conjunction with an over denture.

l. Bridges and dentures, including repairs and adjustments, unless specifically included as a Covered Service in the "Summary of Dental Plan Benefits" section.

m. Replacement of lost or stolen dentures or charges for duplicate dentures.

n. Orthodontic Services and procedures related to Orthodontic Services, such as, but not limited to, x-rays, extractions, orthodontic appliance repairs and adjustments, unless Orthodontic Services are specifically included as a Covered Service in the "Summary of Dental Plan Benefits" section.

o. No benefits are payable for accidental bodily injuries arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used-including such benefits mandated by law) of any automobile policy.

p. Any benefit, procedure or service, to treat, modify, correct or change an existing condition or status caused or contributed to by prior medical or dental treatment, when prior treatment was performed in accordance with then generally accepted standards of medicine or dentistry in the local community where performed.

q. Dental benefits and services which are not completed.

r. Treatment rendered outside of the United States or Canada.

s. Services performed for the purpose of full mouth reconstruction are not Covered Services unless shown as a Covered Service in the "Summary of Dental Plan Benefits" section. For example, extensive treatment plans involving ten (10) or more crowns or units of fixed bridgework are considered full mouth reconstruction.

t. Benefits or services for control of harmful habits.

u. Procedures for dental implants and associated services, unless these are specified as Covered Services in the "Summary of Dental Plan Benefits" section.

v. Diagnosis or treatment of temporomandibular joint dysfunction, unless these are specified as Covered Services in the "Summary of Dental Plan Benefits" section.

2. Dental Benefits and Services are Limited as Follows, unless the "Summary of Dental Plan Benefits" section specifies other limitations. Typically, when dental benefits and services are limited under the Plan, any amounts not benefited by DDKS due to the limitation are the responsibility of the Enrollee, up to the amount of the Maximum Plan Allowance (MPA).

a. If a more expensive Covered Service is provided than DDKS determines to be the least costly professionally accepted treatment, DDKS will pay the applicable benefit for the Covered Service which is needed to achieve reasonable functionality.

b. Only the costs of the procedures necessary to prevent or eliminate oral disease and for appliances or restorations required to replace missing teeth are benefited by DDKS under the Plan and then only if specifically included as a Covered Service in the "Summary of Dental Plan Benefits" section.

c. Bitewings taken within twelve (12) months of a full mouth series of x-rays will be disallowed.

d. A panoramic film in conjunction with a full mouth services of x-rays is not a separate benefit.

e. A seven (7) vertical bitewing series is limited to once (1) every two (2) years.

f. Restoration of surfaces on teeth are limited to only once (1) or twice (2) within a twenty-four (24) month period dependent upon the anatomy of the tooth. Restorations on the same tooth done within twenty-four (24) months after a crown is seated are subject to frequency limitations.

g. Recementation of space maintainers are limited to once (1) per arch or quadrant per lifetime.

h. Inlays will automatically receive benefits equal to the corresponding surface of a filling.

i. Individual crowns are not a Covered Service unless specifically included as a Covered Service in the "Summary of Dental Plan Benefits" section. If a Covered Service:

   (1) Individual crowns on the same tooth are limited to only once (1) in any five (5) year period unless needed because of injury. Said time period is to be measured from the date the crown was supplied to the Enrollee whether or not the Agreement was then effective. If a crown is placed on a tooth which has had a restoration in the previous twenty-four (24) month period, benefits paid for the crown are reduced by the benefit paid for the prior restoration.

   (2) Porcelain crowns, porcelain fused to metal, or resin processed to metal type crowns are not benefited by DDKS for any person under twelve (12) years of age due to age limitation.

   (3) Recementation of a crown is limited to only once (1) in a lifetime.

   (4) Repairs per crown are limited to two (2) in a twelve (12) month period.

   (5) Stainless steel crowns are limited to once (1) in a twenty-four (24) month period when placed on a primary tooth. If used as a permanent crown, the limitations of subparagraphs (1); (2); (3); and (4) of this subsection will apply.

   (6) Core build-ups, including pins, are limited to permanent teeth having insufficient tooth structure to build a crown.

j. Prosthodontics are not a Covered Service unless specifically included as a Covered Service in the "Summary of Dental Plan Benefits" section. If a Covered Service, the following limitations apply unless the "Summary of Dental Plan Benefits" section states different limitations:

(1) Not more than one (1) full upper and one (1) full lower denture shall be constructed under the Agreement in any five (5) year period for any Enrollee. Said time period is to be measured from the date the denture was last supplied to the Enrollee whether or not the Agreement was then effective.

(2) A removable prosthetic or fixed prosthetic device, including bridges, or full upper or full lower dentures, may not be provided under the Agreement for any Enrollee more often than once (1) in any five (5) year period. Said time period is to be measured from the last date of service the removable prosthetic or fixed prosthetic device, including bridges, or full upper or full lower dentures was last supplied to the Enrollee whether or not the Agreement was then effective.

(3) Denture reline and rebase is limited to only once (1) in any thirty-six (36) month period for Enrollee.

(4) Denture adjustments are limited to only two (2) times in any twelve (12) month period for an Enrollee.

(5) Crowns when used for abutment purposes are benefited at the same co-payment percentage as provided under the Plan for bridges and complete and partial dentures.

(6) Recementation of a bridge is limited to only once (1) in a lifetime.

(7) If teeth are missing in both quadrants of the same arch, benefits are allowed for a bilateral partial toward the procedure submitted. If a fixed bridge or other more expensive procedure is selected, an allowance for a partial denture is made to restore the arch to contour and function.

(8) Only two (2) repairs per prosthesis, such as bridges, partials, or dentures, will be allowed in a twelve (12) month period.

(9) Tissue conditioning is limited to no more than two (2) per arch each thirty-six (36) months.

k. Endodontic procedures are not Covered Services unless specifically included as a Covered Service in the ”Summary of Dental Plan Benefits” section.

l. Periodontic procedures are not Covered Services unless specifically included as a Covered Service in the ”Summary of Dental Plan Benefits” section. When covered, payment is limited to only once (1) in any twenty-four (24) month period for all non-surgical periodontal procedures with the exception of the full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subject to the same limitations and is limited to one (1) per lifetime; periodontal maintenance which is limited to once (1) in any six (6) month period; and crown lengthening which carries no frequency limitation. For surgical periodontal

procedures, when covered, payment is limited to only once (1) in any thirty-six (36) month period.

m. Treatment to correct congenital or developmental malformations.

n. Payment for anesthesia and IV (intravenous) sedation is limited to only for surgical extractions which are Covered Services and is limited to a maximum of one (1) hour, per episode.

o. Orthodontic Services are not Covered Services unless specifically included as a Covered Service in the "Summary of Dental Plan Benefits" section.

3. Certain dental benefits and services may be disallowed under the Plan. When dental benefits or services are disallowed, the fees associated with those items are neither benefited by DDKS nor collectable from the Enrollee by a Participating Dentist. Disallowed services will be so indicated on the applicable Enrollee's Explanation of Benefits.

ELIGIBILITY OF EMPLOYEES AND THEIR DEPENDENTS

1. Eligible Employee:

To qualify as an Eligible Employee, an individual must meet one (1) of the following requirements:

a. Be an employee who is:

(1) Actively employed to work for Employer a regularly scheduled minimum twenty (20) hour per week or thirty (30) hour per week if a substitute teacher;

(2) On paid sick leave from such active employment;

(3) On any other approved leave of absence from such active employment; or

b. Be a former employee of Employer who is entitled to retirement benefits from Employer and meets all other requirements for coverage as determined by Employer.

c. Be a member in good standing of an organization, association or union which is the Employer, as determined under the rules of such organization, association or union.

d. Be a self-employed person who is actively engaged in a trade or business with at least one (1) other self-employed person or employee, all as determined by DDKS.

2. Commencement of Coverage for Employee:

a. With respect to a person who is an Eligible Employee on the Effective Date, coverage hereunder shall begin upon such person becoming a Subscriber.

b. With respect to a person who is not an Eligible Employee on the Effective Date, then coverage hereunder shall begin the first day of the month following the later of i) such person becoming a Subscriber, or ii) the effective date associated with the Employer designated enrollment period.

c. With respect to a person who is an Eligible Employee who experiences a "qualifying event", such Eligible Employee may make a new election within thirty-one (31) days of the qualifying event that corresponds to the gain or loss of eligibility and/or coverage under the Plan, or a plan of the Spouse's or Dependent's employer, that was caused by the occurrence of such qualifying event. Changes in coverage will become effective on the first day of the month coincident with or following the later of: i) the month in which the Eligible Employee becomes a Subscriber, ii) the effective date specified in the election, or iii) the submission of any required enrollment information and the payment of any required premium to DDKS. For purposes of the "Eligibility of Employees and Their Dependents" section, a "qualifying event" is any of the events described below:

(1) Legal Marital Status. A change in an Eligible Employee's legal marital status such as marriage or divorce.

(2) Number of Dependents. A change in the Eligible Employee's number of Dependents, including the birth and/or adoption of a child.

(3) Gaining or Losing Coverage Eligibility under another Employer's Plan. A change in coverage or eligibility status in which an Eligible Employee or Eligible Dependent gains or loses eligibility for coverage under a plan that is available to the Eligible Dependent. In such event an Eligible Employee may elect to cease or become covered under the Dependent's employer's plan.

3. No Coverage as Both Employee and Dependent:

No person may be insured both as an Eligible Employee and as an Eligible Dependent, and no person will be considered as an Eligible Dependent of more than one (1) Employee. Eligible Dependents do not include another Employee of the Employer who is insured under any employer-sponsored program providing dental expense coverage. A Child who may be otherwise eligible as a dependent under more than one (1) dental plan sponsored by the Employer, shall be covered under the plan of the Employee as explained in the "Non-Duplication of Benefits" section.

4. Commencement of Coverage for Dependent:

a. With respect to a person who is an Eligible Dependent on the Effective Date, coverage hereunder shall begin for such Eligible Dependent upon the later of i) the first day that the coverage commences for the Subscriber, or ii) the date such person satisfies the requirements to become an Enrollee.

b. With respect to a person who is an Eligible Dependent who is not an Enrollee on the Effective Date, if the Employer elects annual open enrollment, then coverage hereunder shall begin upon the later of i) the Subscriber with respect to whom such person is a dependent becoming a Subscriber, ii) the date upon which such person satisfies the requirements to become an Enrollee, or iii) upon the effective date associated with such open enrollment period.

c. With respect to a person who becomes an Eligible Dependent and therefore qualifies for coverage as a result of a qualifying event, then coverage hereunder shall begin upon the first day of the month coincident with or following the later of i) the Subscriber with respect to whom such person is a dependent becoming a Subscriber, ii) the date upon which such person satisfies the requirements to become an Enrollee.

5. Termination of Benefits:

a. If, at any time, a Subscriber fails to satisfy all of the requirements of the Agreement, coverage under the Agreement shall terminate for such Subscriber, and each dependent of such Subscriber, in the following manner:

1) If the Subscriber qualifies for, timely elects and timely pays for Continuation Coverage, then the Subscriber shall continue to be covered for the applicable period during which coverage must be provided and during which premiums are timely paid, and thereafter coverage shall terminate;

2) If the Subscriber fails to qualify for, timely elect or timely pay for Continuation Coverage, then coverage shall terminate at the end of the premium period in which the Subscriber first ceases to satisfy such requirements.

b. If, at any time, an Enrollee who is not the Subscriber ceases to qualify as Eligible Dependent, coverage under the Agreement shall terminate:

1) If the Enrollee qualifies for, timely elects, and timely pays for Continuation Coverage, then the Enrollee shall continue to be covered for the applicable period during which coverage must be provided and during which premiums are timely paid, and thereafter the coverage shall terminate;

2) If the Enrollee fails to qualify for, timely elect, or timely pay for Continuation Coverage, then coverage shall terminate at the end of

premium period in which the Subscriber upon whom such person is dependent ceases to constitute a Subscriber, or at the time such dependent ceases to qualify as an Eligible Dependent, whichever occurs first.

d. At termination of coverage under the Agreement, operative procedures which are then in progress and i) which are completed within thirty (30) days of the termination of coverage, and ii) submitted for payment within six (6) months of such termination shall be covered. For this purpose, operative procedures are defined as and limited to root canal therapy on permanent teeth; individual crowns; dentures, partial and complete; and bridges. Operative procedures are considered in progress only if all procedures for commencement of lab work have been completed.

6. Non-Duplication of Benefits:

A. GENERAL.

This section entitled Non-Duplication of Benefits addresses coordination of benefits (COB) and applies when a person has dental care coverage under more than one plan. The term "plan" is defined below. The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

B. DEFINITIONS.

(1) A "plan" is any of the following that provides benefits or services for dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(a) The term "plan" includes group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.

(b) The term "plan" does not include individual or family insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of $200 or less per day; school accident type coverage, benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies, and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under (a) or (b) is a separate plan. If a plan has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is treated as a separate plan.

(1) The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.

When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

(3) "Allowable expense" means a dental care service or expense, including deductibles and co-payments, or co-insurance that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

(a) If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.

(b) The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions. Examples of these provisions are second opinions, precertification requirements, and preferred provider arrangements.

(4) "Claim determination period" means a contract year. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.

(5) "Closed panel plan" is a plan that provides dental benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

(6) "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

C. ORDER OF BENEFIT DETERMINATION RULES.

When two (2) or more plans pay benefits, the rules for determining the order of payment are as follows:

(1) The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

(2) A plan that does not contain a coordination of benefits, maintenance of benefits, or non-duplication of benefits provision that is consistent with the "Non-Duplication of Benefits" section is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(3) A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

(4) The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

(a) The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two (2) plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

(b) The order of benefits when a child is covered by more than one plan is:

1. The primary plan is the plan of the parent whose birthday is earlier in the year if:

a. The parents are married;

b. The parents are not separated (whether or not they ever have been married); or

c. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

e. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

2. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

3. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

a. The plan of the custodial parent;

b. The plan of the spouse of the custodial parent;

c. The plan of the noncustodial parent; and then

d. The plan of the spouse of the noncustodial parent.

(c) The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an 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 is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the order described in the "C. Order of Benefit Determination Rules 4(a)."

(d) If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. 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 is ignored.

(e) The plan that covered the person as an employee, member, subscriber or retiree longer is primary.

(f) If a health plan includes coverage for dental procedures under the major medical provisions of the plan, that plan is primary.

(g) If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

D. EFFECT ON THE BENEFITS OF THIS PLAN.

(1) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than one hundred percent (100%) of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:

(a) Determine its obligation to pay or provide benefits under its contract;

(b) Determine whether a benefit reserve has been recorded for the covered person; and

(c) Determine whether there are any unpaid allowable expenses during that claims determination period.

If there is a benefit reserve, the secondary plan will use the covered person's benefit reserve to pay up to one hundred percent (100%) of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

(2) If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts about coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. DDKS may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. DDKS need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give DDKS any facts it needs to apply those rules and determine benefits payable.

F. FACILITY OF PAYMENT.

A payment made under another plan may include an amount that should have been paid under this plan. If it does, DDKS may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. DDKS will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

G. RIGHT OF RECOVERY.

If the amount of the payments made by DDKS is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

DELTA DENTAL OF KANSAS
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions concerning this notice, please contact:
Privacy Officer
Delta Dental of Kansas
P.O. Box 789769
Wichita, KS 67278-9769
(316) 264-1099 or (800) 733-5823

Delta Dental of Kansas, Inc. (the "Plan") is required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information and we are committed to protecting the privacy and confidentiality of your health and personal information.

HOW THE PLAN MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Uses and Disclosures of Protected Health Information Without Your Specific Authorization

The Plan may use and disclose your health information about you for payment or health care operations without any consent or authorization beyond your enrollment in the Plan.

Payment means activities related to the Plan's payment to pay you or your health care provider for covered expenses. Activities associated with payment include, but are not limited to, enrollment activities; collection of contributions from you and your employer; payment for covered expenses, including coordination of benefits; review of payment decisions upon appeal; activities related to pre-authorization of benefits and utilization review; and disclosure of contribution payment history to a consumer reporting agency.

Health Care Operations means activities undertaken to administer your program including, but not limited to, activities necessary to reduce overall health care costs; contacting you or your health care provider about alternative treatments; evaluating practitioner and provider performance; training of non-health care professionals; activities related to obtaining an insurance contract, such as census rating for premiums; conducting or arranging for claims review, legal services, and auditing functions; fraud and abuse detection and compliance-related activities; analysis related to managing and operating the Plan; development or change of payment methods or coverage policies; and educational activities.

Under applicable federal law, there are other uses and disclosures the Plan may make without your specific authorization some are included below:

Disclosures of Protected Health Information to the Plan Sponsor. The Plan will disclose protected information only to the minimal extent it helps your employer administer the program, such as providing billing information, and confirmation of enrollment. The employer must limit its use of that information to obtaining quotes or modifying, amending, or terminating the Plan.

Creation of de-identified health information. The Plan may use your protected health information to create de-identified health information. This means that all data items that would help identify you, such as name, address, birth date, and hire date are removed or modified. Once information is de-identified it is no longer protected.

Furnishing data to Business Associates. The Plan's Business Associates (e.g., printers, mailing services, legal counsel, and consultants) receive and maintain your protected health information to carry out payment and health care operations.

Uses and disclosures required by law. The Plan will use and/or disclose your protected health information when required by law to do so. The disclosure will be the minimum necessary to fulfill the legal requirement.

Disclosures for public health activities. We may disclose your protected health information for the following public health activities in circumstances that would help prevent or control disease, report child abuse, and domestic violence. Such disclosure will be made only to extent required by law or with your agreement.

Disclosures for health oversight activities. The Plan may disclose your protected health information to a health oversight agency for oversight activities to complete applicable audits, investigations or inspections.

Disclosures for judicial and administrative proceedings. Your protected health information may be disclosed during any judicial or administrative proceeding as required by appropriate administrative or judicial court proceedings.

Disclosures for law enforcement purposes. We may disclose your protected health information to a law enforcement official as required by law or to comply with a court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer.

Disclosures regarding victims of a crime or to avert a serious threat to health or safety. In response to a law enforcement official's request, the Plan may disclose information about you with your approval or in an emergency situation and you are incapacitated, or if it appears you were the victim of a crime. We may also disclose your protected health information to prevent or lessen a serious and imminent threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

Disclosures for specialized government functions. The Plan may disclose your protected health information as required to comply with governmental requirements for national security reasons or for protection of certain government personnel or foreign dignitaries.

Fundraising. We may send you information as part of our fundraising activities. You have the right to opt out of receiving this type of communication.

Other Uses and Disclosures Requiring Your Authorization. All other uses and disclosures of your health information, including family members or any other individual not already authorized to receive protected health information, will be made by the Plan only with your express written authorization.

Furthermore, while the Plan does not typically use or disclose your protected health information for marketing purposes; sell your protected health information for direct or indirect financial benefit or non-financial benefit (i.e. in-kind item or service); or retain, use or disclose psychotherapy notes, if the Plan does intend to engage in such activity, your authorization will be obtained as required by law prior to engaging in said activity.

If you provide authorization for any use or disclosure of your protected health information, you may revoke that authorization, in writing, at any time. The revocation will not apply to any previous use or disclosure.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right To Inspect and Copy. You have the right to inspect and copy health information collected and maintained by the Plan. To inspect and copy your health information, you must complete a specific form providing information needed to process your request from the Privacy Officer at the address identified on this Notice. You may request that your health information be provided in an electronic form and we can work together to agree on an appropriate electronic format. You may be charged a fee to cover expenses associated with your request. We can refuse access under certain circumstances. If the Plan refuses access, you will be notified in writing and may be entitled to have a neutral person review the refusal.

Right To Amend Incorrect or Incomplete Information. You may request that Plan change your health information, although we are not required to do so. If your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make your request in writing. You must also provide a reason for your request.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you, with certain exceptions specifically defined by law. To request this list or accounting of disclosures, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice.

Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request restrictions, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice.

We are not required to agree to your request for restrictions. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Right to Request Alternative Methods of Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request an alternative method of communications, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the person identified on the first page of this Notice. You may obtain a copy of this notice at our website, http://www.deltadentalks.com.

Right to Breach Notification. You have the right to be notified if we determine that there has been a breach of your protected health information.

COMPLAINTS

If you believe your rights with respect to health information about you have been violated by the Plan, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the person identified on the first page of this Notice. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

The effective date of this Notice is September 23, 2013. The Plan reserve the right to change the terms of this notice and to make the revised notice effective with respect to all protected health information regardless of when the information was created. If the notice is revised, the new notice will be provided to you, if you are still covered by the Plan, either through e-mail or U.S. postal service, within sixty days of such revision. Otherwise, we will provide you once every three years a reminder of the availability of this Notice and how to obtain the Notice.

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APPENDIX C
HEALTH FLEXIBLE SPENDING ACCOUNT

This Appendix C contains the terms and conditions specific to the USD #262 Valley Center Health Flexible Spending Account benefit that may be elected under Section 4.01 of the Plan. Under this benefit, a Participant may be reimbursed, on a pre-tax basis, for Qualified Medical Expenses incurred during a Plan Year. Unless otherwise altered by the terms of this Appendix C, the terms and conditions of the Plan are incorporated into, and made applicable to, the Health FSA.

ARTICLE C-I
PARTICIPATION IN THE HEALTH FLEXIBLE SPENDING ACCOUNT

Section C1.01 Eligibility/Plan Entry Dates. The eligibility conditions and plan entry dates are the same as those for the Plan.

Section C1.02 Election to Participate. To become a Participant in this Health FSA, an Eligible Employee must make an election under the Plan to participate in this Health FSA. Such an election must be made pursuant to the terms and provisions of the Plan.

(a) *Special Rule for Carryover Amounts.* If a Participant does not elect to participate in the Health FSA for the Plan Year, but the Participant has a Carryover Amount (defined below) from a prior Plan Year, the Participant will be automatically re-enrolled in this Health FSA with an election of zero dollars. The sole purpose of the election of zero dollars is to allow the Participant the opportunity to spend the Carryover Amount. This special rule for Carryover Amounts shall apply unless an affirmative forfeiture has been made by the Participant as set forth in subparagraph (b) below.

(b) *Affirmative Forfeiture of Carryover Amount*. A Participant may affirmatively and voluntarily forfeit his/her Carryover Amount if he/she does not want to be automatically re-enrolled with a zero dollar election, as set forth in subparagraph (a) above. Such affirmative and voluntary forfeiture must be made on a form prescribed by either the Plan Administrator or Claims Administrator.

(c) *Special Rule if Enrolled in the High Deductible Health Plan Option.* In the event a Participant with a Carryover Amount from a prior Plan Year enrolls in a high deductible health plan sponsored or maintained by the Employer, and the Participant is eligible to enroll in a Limited-Scope Health FSA that is sponsored or maintained by the employer, the Plan Administrator, may establish a procedure whereby, in the absence of an affirmative election by the Participant to the contrary, any Carryover Amount is automatically carried forward from the Employer's General-Purpose Health FSA to the Employer's Limited-Scope Health FSA.

Section C1.03 Effective Date of Election. An election to participate in this Health FSA shall take effect as follows:

(a) If an Eligible Employee's election was made during the Annual Enrollment Period under the Plan, the election shall take effect as of the first day of the next Plan Year;

(b) If the Eligible Employee's election was made within thirty (30) days after the Eligible Employee first became eligible to participate in this Health FSA, the election shall take effect as of the first day of the month following or coincident with the date that the completed election form is received by the Plan Administrator; or

(c) If the Eligible Employee's election was made within thirty (30) days after an event that would allow an election change to be made under the terms of the Plan, the election shall take effect as of the first day of the month on or after the date that the completed election form is received by the Plan Administrator; provided, however, that this Section C1.03(c) shall apply if and only if the Eligible Employee had not previously been a Participant in this Health FSA at any time during the Plan Year.

Section C1.04 Election Changes. Once an Eligible Employee has become a Participant in this Health FSA, he/she may make an election change after the beginning of a Plan Year in accordance with, and as permitted by, Article V.

Section C1.05 FMLA Leave. A Participant who is taking or returning from FMLA leave shall have the following options with respect to his/her participation in this Health FSA:

(a) *Taking FMLA Leave.* Upon commencement of FMLA leave, a Participant may continue his/her coverage under this Health FSA by continuing to pay the applicable premium during the period of the FMLA leave or by making such other arrangements as may be permitted under the provisions of the Plan. Alternatively, upon commencement of FMLA leave, a Participant may revoke his/her participation in this Health FSA, in which event the Participant will no longer be covered under this Health FSA as of the date that his/her FMLA leave commenced.

(b) *Returning from FMLA Leave.* If a Participant's participation in this Health FSA was terminated when the Participant began his/her FMLA leave, the former Participant may, upon returning to work from an FMLA leave, elect to resume his/her participation in this Health FSA as of the date that he/she returns to work.

(i) Such a Participant may elect to resume coverage at the prior coverage level, in which event the Participant will be required to make up the premiums that would have been due during the period the Participant was on FMLA leave.

(ii) In lieu of making up the missed premiums, such a Participant may instead choose to resume coverage at a reduced level. In such an event, the Participant's coverage for the Plan Year shall be reduced on a pro rata basis by the portion of the Plan Year that the Participant was absent from work due to his/her FMLA leave.

ARTICLE C-II
MEDICAL REIMBURSEMENT

Section C2.01 Definition of a Dependent. The term "Dependent," for purposes of participation in this Health FSA, means the following:

(a) *Children Through Age Twenty-Six (26).* The Participant's natural child, lawfully adopted child (including a child placed with the Participant for adoption but for whom the adoption is not yet final), stepchild, or other child for whom the Participant has obtained legal guardianship pursuant to a court order, until such child attains age twenty-six (26) (or until such child attains age eighteen (18) in the case of a legal guardianship). Children placed with a Participant for adoption and Children who are the subject of a Qualified Medical Child Support Order will also be considered Dependents.

(b) *Disabled Children Above Age Twenty-Six (26).* The Participant's natural child, lawfully adopted child (including a child placed with the Participant for adoption but for whom the adoption is not yet final), stepchild, or other child for whom the Participant has obtained legal guardianship pursuant to a court order, who is unmarried and incapable of self-sustaining employment by reason of mental retardation or physical disability and for whom the Participant is the major source of financial support, from the end of the calendar month in which the Child attains age twenty-six (26).

(c) *Non-Children Dependents.* Any relatives of the Participant who reside in the Participant's home, are claimed by the Participant as a tax dependent, and meet the definition of a tax dependent under Code § 152. This includes "any qualifying relative within the meaning of Code § 152(a)(2), without regard to subsections (b)(1), (b)(2) or (d)(1)(B)."

Section C2.02 Qualified Medical Expense. The term "Qualified Medical Expense" means an expense incurred by the Participant, or by the Spouse or Dependent (as defined in Section C2.01 above) of a Participant, for medical care as defined in Code § 213(d). The term includes, but is not limited to, amounts paid for hospital bills, doctor and dental bills or prescription medicine and drugs, but does not include reimbursement paid for other health coverage for other plans maintained by the Employer or reimbursement for over-the-counter drugs or medicine (other than insulin) that are not purchased pursuant to a prescription.

Section C2.03 Carryover Amount. For purposes of reimbursements under this Health FSA, Carryover Amount means any amount not greater than $500 remaining in the Participant's account from the immediately preceding Plan Year as determined on the last day of the Run-Out Period for that Plan Year. Any amount remaining in excess of the Carryover Amount shall be forfeited.

Section C2.04 Run-Out Period. The Run-Out Period means the period following the end of the Plan Year during which the prior Plan Year Claims may be submitted to the Employer for reimbursement. The Run-Out Period under this Health FSA ends on September 30.

Section C2.05 Reimbursement.

(a) *General Rule*. The Employer will reimburse the Participant in the Plan Year for Qualified Medical Expenses incurred by the Participant during the Plan Year subject to the other limitations of this Health FSA.

(b) *Special Carryover Rule.* A Participant may also be reimbursed for Qualified Medical Expenses in a subsequent Plan Year from his/her Carryover Amount.

Unless specifically requested otherwise by a Participant, reimbursements during the Run-Out Period for current-year claims will be made from current-year amounts in order to maximize the potential Carryover Amount.

(c) *Electronic Payments.* If the Employer permits the use of an electronic payment card, such as a debit card, such card may be used to pay for Qualified Medical Expenses at merchants and service providers which are authorized by the Employer.

The Employer will not make any reimbursement to a Participant if the Participant receives reimbursement for the expense through insurance or under any other means. The Employer will only reimburse for Qualified Medical Expenses incurred while the employee participates in the Health FSA. An expense is incurred when the Participant is provided with the medical care that gives rise to the Qualified Medical Expenses, and not when the Participant is formally billed or charged for, or pays for the medical care.

Section C2.06 Reimbursable Qualified Medical Expenses. The following expenses constitute Qualified Medical Expenses, as defined in C2.02, that may be reimbursed under this Health FSA:

(a) Deductibles and copayment amounts the Participant pays under his/her medical and/or dental and/or vision care coverage;

(b) Medical and/or dental and/or vision care expenses in excess of usual, reasonable and customary rates; and

(c) Any Code § 213(d) medical, dental, or vision care expenses not reimbursed by insurance; provided, however, over-the-counter drugs or medicine (other than insulin) that are not purchased pursuant to a prescription are not eligible for reimbursement as Qualified Medical Expenses.

The Plan Administrator has discretion to construe and apply what may be reimbursable under this Plan in accordance with such final or informal guidance as the IRS might provide.

Section C2.07 Maximum Amount of Reimbursement. The maximum amount of reimbursement for any Plan Year is the dollar amount that the Participant elected to contribute to his/her Health FSA for that Plan Year plus the amount, if any, of the Carryover Amount from the previous Plan Year. The Employer will reimburse the Participant throughout the coverage period for Qualified Medical Expenses up to the maximum amount of reimbursement, as set forth in this Section, without regard to the actual amount that the Participant has contributed to his/her Health FSA as of the date a claim for reimbursement was submitted.

(a) *Limit on Amounts Elected by the Participant.* The dollar amount elected by the Participant may not exceed the dollar limit established by the Employer for that Plan Year.

(b) *Dollar Limit Established by the Employer.* The dollar limit established by the Employer for a Plan Year will be equal to the dollar limit set forth in the Code (as indexed annually for cost-of-living adjustments by the IRS); provided, however, that the Employer may elect to establish a lower dollar limit for a Plan Year.

(c) *Communication to Eligible Employees.* The dollar limit established by the Employer for a Plan Year must be communicated by the Plan Administrator to Eligible Employees in the enrollment materials for the Health FSA.

(d) *Special Carryover Rule.* The maximum reimbursement amount as set forth in this Section may be increased by any Carryover Amount, as defined in Section C2.03 above.

Section C2.08 Withholding - Accounting. The Employer will establish and maintain a Health FSA for each Participant who has elected to receive the Health FSA benefit under this Health FSA. The Employer will credit to the Participant's Health FSA an amount of the Participant's Compensation which he/she elects to reduce. The amounts credited to the Participant's Health FSA are the property of the Employer until the Employer actually makes reimbursement to the Participant. The Employer will debit a Participant's Health FSA for the amount of the reimbursement made for the Participant. A Participant's Health FSA will never exceed the dollar amount specified in Section C2.07 above of this Health FSA.

Section C2.09 Year End Accounting - Forfeitures. The Employer will use the amount credited to a Participant's Health FSA for any Plan Year to reimburse the Participant for Qualified Medical Expenses or to make a "qualified reservist distribution" in accordance with Article C-IV, Sections C4.01 through C4.06 of this Appendix C. If any balance, other than any

portion of the balance that qualifies as a Carryover Amount, remains in the Participant's Health FSA for any Plan Year after the Employer has made the reimbursements and/or "qualified reservist distribution" for the Plan Year, the Participant will forfeit the unused amount. Within a given Plan Year, if the total forfeitures from all Participants exceed the total reimbursement amount, then the Health FSA will have a surplus. The amount of the surplus, if any, will be determined after the end of the Claims Run-Out Period, defined in C2.04, and after all pending Claims have been processed. Any surplus will be used to offset reasonable administrative costs. Any excess still remaining after such costs are paid will be used to reduce the required premiums under the Health FSA for all Employees participating in the Health FSA in the Plan Year following the Year in which the surplus was created. Participants for this purpose will be determined on the date of the first payroll following the date on which the amount of surplus has been determined.

Section C2.10 Termination of Health FSA by the Employer - Forfeitures. If the Health FSA is terminated by the Employer either before or at the end of the Plan Year and the total contributions from all Participants exceed the total Health FSA reimbursements, then the Employer will use the surplus to offset reasonable administrative costs. Any surplus remaining after reasonable administrative costs have been paid shall be distributed *per capita* to all Participants who participated in the Health FSA in the year in which the surplus was gained. In no case will the surplus be allocated to a Participant based directly or indirectly on his/her Claims experience. The administrative costs will not be offset and the surplus, if any, will not be distributed until the Claims Run-Out period has expired and all pending Claims have been processed.

ARTICLE C-III
CLAIMS PROCEDURE

Section C3.01 Submission of Claims. A Participant desiring to be reimbursed for medical expenses must apply for reimbursement by completing the application form provided by the Claims Administrator. A Participant may also access his/her Health FSA through the use of an electronic payment card, provided that the Claim is properly adjudicated, as set forth in Section C3.03.

Subject to Section C5.01 of this Plan, a Participant must submit the application for reimbursement for expenses incurred during a Plan Year before the end of the Run-Out Period, defined in Section C2.04. The Claims Administrator may require the Participant to provide such information as may reasonably be required to process the Claims, including, but not limited to, the following:

(a) The amount, date incurred, and nature of each expense;

(b) The name of the person, organization, or entity with whom the expense was incurred;

(c) The name of the person for whom the expense was incurred;

(d) The amount (if any) recovered under any insurance arrangement or other plan, with respect to the expense; and

(e) A statement that the expense (or portion thereof for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any other health plan coverage.

Such application shall be accompanied by a written statement from an independent third party, stating that the expense has been incurred and the amount of the expense, and by such other bills, invoices, receipts, or other statements or documents that the Claims Administrator may request. Such application may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.

Section C3.02 Claims Administration. Surency will act as Claims Administrator with respect to any claim for benefits under this Health FSA. Surency has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the Surency Benefit Description.

Section C3.03 Electronic Payment Card Reimbursements. If the funds in a Health FSA are accessible by electronic debit card a Participant must comply with the substantiation and correction procedures in accordance with Rev. Rul. 2003-43 and other IRS guidance. A debit card that is presented as payment for a medical expense and denied at the point-of-sale (i.e., when the service or item is provided) does not constitute an initial Claim denial under these procedures.

Section C3.04 Limitation on Reimbursements With Respect to Certain Participants. Notwithstanding any other provision of this Health FSA, the Plan Administrator may limit the amounts reimbursed with respect to any Participant who is a highly compensated individual (within the meaning of Code §105(h)(5) or §125(e)) to the extent the Claims Administrator deems such limitation to be advisable to assure compliance with any nondiscrimination provision of the Code. Such limitation may be imposed whether or not it results in a forfeiture under Section C2.09 of this Health FSA.

Section C3.05 Time Frame for Deciding Claims. If any Claim for benefits under this Health FSA is denied, in whole or in part, then the Claims Administrator shall promptly furnish to the Claimant, within thirty (30) days of receipt of the Claim, written notice:

(a) Setting forth the reason for the denial;

(b) Making reference to pertinent Health FSA provisions upon which the denial is based;

(c) Describing any additional material or information from the Claimant which is necessary and why;

(d) Referencing any internal rule, guideline, protocol, or similar criterion relied upon in making the adverse determination (if applicable); and

(e) Explaining the Claim review procedure set forth herein, including applicable time limits.

Section C3.06 Extension of Time Frame for Deciding Claims. The Claims Administrator may seek one (1) extension of up to fifteen (15) days in order to make the benefit determination. The extension must be sought due to matters beyond the control of the Plan and the Claimant must be notified of the extension prior to the expiration of the initial thirty (30) day period. If the extension is due to the failure of the Claimant to submit information necessary to decide the Claim, the notice of extension shall specifically describe the required information and the Claimant shall have at least forty-five (45) days from receipt of the notice to provide the specified information. The period for making the benefit determination shall be tolled from the time the notification of extension is sent until the date on which the Claimant responds to the request for information.

Section C3.07 Appealing a Claim Denial. Any Claimant seeking review hereunder has one hundred eighty (180) days to submit the Appeal. The Claimant may, upon request and free of charge, examine all pertinent documents and may submit issues and comments in writing.

Section C3.08 Time Frame for Deciding Appeal. The Plan Administrator shall render a decision on review no later than sixty (60) days after receipt of the request for review hereunder unless special circumstances require an extension of time (not to exceed sixty (60) days from the date of the initial 60-day period). The Participant shall be furnished with written notice of any such extension.

Section C3.09 Decision on Appeal. In conducting the review, no deference shall be given to the initial adverse determination, and a plan fiduciary, other than the one who originally decided the Claim (or the person's subordinate), shall make the determination upon Appeal. The decision on review shall be in writing. If the Claim is once again denied, in whole or in part, then the notification shall (a) state the reason for the decision, (b) refer to the Health FSA provisions upon which it is based, (c) state that the Claimant is entitled to receive (upon request and free of charge) reasonable access to, and copies of, all relevant information, and (d) describe any voluntary Appeals procedures.

ARTICLE C-IV
QUALIFIED RESERVIST DISTRIBUTIONS

Section C4.01 Qualified Reservist Distributions ("QRD"). A "qualified reservist distribution" is a distribution of all or a portion of the account balance of a Participant who is called to active military service, provided the call to active military service is for a period of one hundred eighty (180) or more days or for an indefinite period of time.

Section C4.02 Amount of the QRD. Unless a lesser amount is specifically requested, the QRD will be the total of the Participant's contributions as of the date of the approval of the QRD request minus the amount of any Qualified Medical Expense reimbursements received as of the date of the request for the QRD.

Section C4.03 Time Frame for Requesting a QRD. A Participant must request a QRD on or after the date the Participant is called to active military service and prior to the end of the Run-Out Period immediately following the Plan Year in which the Participant is called to such service.

Section C4.04 Time Frame for Plan Administrator to Respond to a Request for a QRD. The Claims Administrator shall respond to any timely request for a QRD within sixty (60) days of the date it receives the request, including providing payment of the distribution within such time frame if the request is approved. If the request is denied, the Claims Administrator shall follow the claims procedures set forth in Article C-III of this Appendix C, except that the time frame set forth in Section C3.05 shall be sixty (60) days instead of thirty (30) days.

Section C4.05 Eligible Claims. A Participant who requests a QRD forfeits the right to receive reimbursements for Qualified Medical Expenses incurred after the date of his/her last day of active employment. Such Participant shall be reimbursed for Qualified Medical Expenses properly submitted for reimbursement prior to the end of the Run-Out Period immediately following the end of the Plan Year and incurred on or prior to the last day of active employment, provided that the total dollar amount of such claims does not exceed the amount of the Participant's election minus the sum of his/her QRD and prior reimbursements received for the Plan Year.

Section C4.06 No Penalty on QRD. The QRD will not be subject to a distribution penalty. The amount of the QRD, however, will be included in the Participant's gross wages for the Plan Year in which the distribution is made, as required by the Internal Revenue Code and applicable IRS guidance.

ARTICLE C-V
TERMINATION OF PARTICIPATION IN THE HEALTH FLEXIBLE SPENDING ACCOUNT AND CONTINUATION OF COVERAGE

Section C5.01 Termination of Participation.

(a) *General Rule.* A Participant will cease participation in this Health FSA on the earlier of the following dates:

(i) The date on which this Health FSA terminates; or

(ii) The date on which the Participant ceases to be an Eligible Employee.

(b) *Effect of Ceasing to be a Participant*. If a Participant ceases to be a Participant in this Health FSA for any reason, the Participant's election to receive reimbursements for Qualified Medical Expenses terminates on that date. The Participant may only receive reimbursement for Qualified Medical Expenses incurred within the same Plan Year and prior to the first day after the day the Participant terminates participation in this Health FSA.

(c) *Continuation Coverage*. Notwithstanding anything in this Section to the contrary, an individual who would normally be required to terminate participation may continue to be a Participant in this Health FSA if and to the extent such an individual elects continuation of benefits under the rules in Section C5.02 below.

(d) *Reimbursement.* If a Participant ceases participation under this Health FSA, the Participant must apply for reimbursement in accordance with Article C-III within the 30-day period following the date the Participant ceases to be a Participant.

(e) *Electronic Payment Card.* A Participant will not be authorized to continue use of an electronic payment card, such as a debit card, to access funds in his/her Health FSA, effective the date of his/her termination from employment. Any claim submitted following a Participant's termination must be submitted in paper form.

Section C5.02 Continuation of Coverage. A Participant who will lose coverage under this Health FSA may have the right to continue coverage under this Health FSA if permitted under the terms and conditions of Article VIII except that (a) COBRA continuation coverage will not be offered if the Participant has overspent his/her account and (b) the maximum period of COBRA coverage described in Section 8.01(e) is limited to the remainder of the Plan Year.

Section C5.03 Limits on Continuation Coverage. Reimbursements under Section C5.02 above shall be made for expenses incurred in any Plan Year only if the Participant applies for such reimbursement in accordance with Article C-III within the Run-Out Period following the close of the Plan Year. In the event of the Participant's death, the Participant's Spouse (or, if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements pursuant to Article C-III above. No reimbursement shall exceed the remaining balance, if any, in the Participant's health flexible spending account for the Plan Year in which the expenses were incurred.

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APPENDIX D
DEPENDENT CARE ASSISTANCE PLAN

This Appendix D contains the terms and conditions specific to the USD #262 Valley Center Dependent Care Assistance Plan that may be elected under Section 4.01 of the Plan. Under this DCAP, a Participant may be reimbursed, on a pre-tax basis, for Qualified Dependent Care Expenses incurred during a Plan Year. Unless otherwise altered by the terms of this Appendix D, the terms and conditions of the Plan are incorporated into, and made applicable to, this DCAP.

ARTICLE D-I
PARTICIPATION IN THE DEPENDENT CARE PLAN

Section D1.01 Eligibility/Plan Entry Dates. The eligibility conditions and plan entry dates are the same as those for the Plan.

Section D1.02 Election to Participate. To become a Participant in this DCAP, an Eligible Employee must make an election under the Plan to participate in this DCAP. Such an election must be made pursuant to the terms and provisions of the Plan.

Section D1.03 Effective Date of Election. An election to participate in this DCAP shall take effect as follows:

(a) If an Eligible Employee's election was made during the Annual Enrollment Period under the Plan, the election shall take effect as of the first day of the next Plan Year;

(b) If the Eligible Employee's election was made within thirty (30) days after the Eligible Employee first became eligible to participate in this DCAP, the election shall take effect as of the first day of the month following or coincident with the date that the completed election form is received by the Plan Administrator; or

(c) If the Eligible Employee's election was made within thirty (30) days after an event that would allow an election change to be made under the terms of the Plan, the election shall take effect as of the first day of the month on, or coincident with, the date that the completed election form is received by the Plan Administrator.

Section D1.04 Election Changes. A Participant in this DCAP may change his/her election during the middle of a Plan Year, either as to participation in this DCAP or as to the dollar amount of the benefit elected, if and only if such an election change is permitted under the terms of the Plan.

ARTICLE D-II
DEPENDENT CARE REIMBURSEMENT

Section D2.01 Qualified Dependent Care Expense. The term "Qualified Dependent Care Expense" means an amount paid by the Participant for care of a Dependent, including related household services, which enables the Participant to be gainfully employed.

(a) *Dependent Care Expenses That Are Not "Qualified."* Qualified Dependent Care Expenses do not include the following:

(i) Amounts paid to a child of the Participant who is under age nineteen (19);

(ii) Amounts paid to an individual for whom the Participant or the Participant's Spouse is entitled to an exemption under Code § 151(c); and

(iii) Amounts paid to a dependent care center that is not a Dependent Care Center as defined in Section (d) below.

(b) *Special Rule for Services Performed Outside the Home.* Amounts paid for services performed outside the Participant's household are not Qualified Dependent Care Expenses unless the expenses are for a Dependent as defined in Section (c)(i) below or a Dependent as defined in Section (c)(ii) below who spends at least eight (8) hours each day in the Participant's home.

(c) *Dependent.* For purposes of this DCAP benefit, the term "Dependent" means an individual meeting the conditions under subparagraphs (i), (ii), or (iii) below as follows:

(i) A tax dependent of the Participant as defined in Code § 152 who is:

(A) Under the age of thirteen (13); and

(B) The Participant's qualifying child as defined in Code § 152(a)(1).

or

(ii) A tax dependent of the Participant as defined in Code § 152, but determined without regard to Code § 152(b)(1), (b)(2) and (d)(1)(B), who:

(A) Is physically or mentally incapable of caring for himself/herself; and

(B) Has the same principal place of abode of the Participant for more than one-half (1/2) of the calendar year;

or

(iii) A Participant's Spouse who:

(A) Is physically or mentally incapable of caring for himself/herself; and

(B) Has the same principal place of abode of the Participant for more than one-half of the calendar year.

Notwithstanding the foregoing, and in accordance with Code § 21(e)(5), in the case of divorced or legally separated parents, a Dependent who is a child shall be treated as a Dependent of the custodial parent (within the meaning of Code § 152(e)) and shall not be treated as a Dependent of the non-custodial parent.

(d) *Dependent Care Center.* The term "Dependent Care Center" means a facility, organized and operated in compliance with all applicable laws and regulations, for care of more than six (6) persons, including one (1) or more Dependents of the Participant, other than persons who reside there and which facility receives a fee, payment, or grant for providing services for any of the six (6) individuals regardless of whether the facility operates at a profit.

Section D2.02 [Reserved]

Section D2.03 Run-Out Period. The Run-Out Period means the period following the end of the Plan Year during which the prior Plan Year Claims may be submitted to the Employer for reimbursement. The Run-Out Period under this DCAP ends on September 30.

Section D2.04 Reimbursement. The Employer will reimburse a Participant for his/her Qualified Dependent Care Expenses incurred by the Participant during the Plan Year subject to the other limitations of this DCAP. The Employer will only reimburse for Qualified Dependent Care Expenses incurred while the Employee participated in the DCAP benefit under the Plan. An expense is incurred when the Participant is provided with the care that gives rise to the Qualified Dependent Care Expense, and not when the Participant is formally billed or charged for, or pays for the care.

(a) *Electronic Payments.* If the Employer permits the use of an electronic payment card, such as a debit card, such card may be used to pay for Qualified Dependent Care Expenses at merchants and service providers which are authorized by the Employer.

Section D2.05 Reimbursable Qualified Dependent Care Expenses. Reimbursable Qualified Dependent Care Expenses do not include:

(a) Education expenses for a child in kindergarten or any higher grade;

(b) Overnight care at a convalescent nursing home for a Dependent;

(c) Overnight camp;

(d) Expenses for lessons, tutoring, or certain types of transportation expenses;

(e) Expenses paid through another policy or DCAP of the Participant or the Participant's Spouse;

(f) Forfeited deposits, but may include application fees, agency fees, and deposits if the Participant is required to pay the expenses to obtain dependent care; or

(g) Expenses incurred before the Participant elected to participate in the DCAP benefit.

Section D2.06 Maximum Amount of Reimbursement. The maximum amount of reimbursement during a Plan Year may not exceed the lesser of the exclusion amount or the earned income limitation. A Participant may not carry over an unused amount to a succeeding year. The exclusion amount for any Plan Year is $5,000 ($2,500 if a married person filing a separate return). The same maximum amount of reimbursement applies per calendar year as specified by the Code. The earned income limitation is the earned income of an unmarried Participant or, for a married Participant, the lesser of the earned income of the Participant or the Participant's Spouse. The Claims Administrator will determine earned income pursuant to Code § 32(c)(2). In no event will the Employer reimburse more than the dollar amount elected by the Participant. Additionally, in no event will the Employer reimburse more than the dollar amount actually credited to the Participant's DCAP for the year minus amounts previously reimbursed for the year.

Section D2.07 Withholding - Accounting. The Employer will establish and maintain a DCAP for each Participant who has elected to receive the DCAP benefit under the Plan. The Employer will credit to the Participant's DCAP an amount of the Participant's Compensation which he/she elects to reduce. The amounts credited to the Participant's DCAP are the property of the Employer until the Employer actually makes reimbursement. The Employer will debit a Participant's DCAP for the amount of the reimbursement made to the Participant. A Participant's DCAP will never exceed the maximum amount specified in Section D2.06 above.

Section D2.08 Year End Accounting - Forfeitures. The Employer will use the amount credited to a Participant's DCAP for any Plan Year to reimburse the Participant for Qualified Dependent Care Expenses. If any balance remains in the Participant's DCAP for any Plan Year after the Employer has made all reimbursements for the Plan Year, the Participant will forfeit the unused amount.

ARTICLE D-III
CLAIMS PROCEDURES

Section D3.01 When to File a Claim. Subject to Section D4.01 of this Appendix D, the Participant must submit the application for reimbursement for expenses for a Plan Year no later than the end of the Run-Out Period.

Section D3.02 How to Submit Claims. A Participant desiring to be reimbursed for Qualified Dependent Care Expenses must make a Claim for reimbursement by completing the application form provided by the Claims Administrator. A Participant may also access his/her DCAP through the use of an electronic payment card, provided that the Claim is properly adjudicated, as set forth in Section D3.03. The Claims Administrator may require the Participant to provide such information as may reasonably be required to process the Claims, including, but not limited to, the following:

(a) The amount and date of services rendered and the nature of each expense with respect to which a benefit is requested;

(b) The name of the person, organization, or entity to which the expense was, or is, to be paid;

(c) The signature of the daycare provider; and

(d) Such other information as the Claims Administrator may, from time to time, require.

Such application shall be accompanied by bills, invoices, receipts, or other statements or certifications showing the amounts of such expenses, together with any additional documentation which the Employer may request. Such application may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.

Claims may be filed by the Participant or by the Participant's duly authorized representative. Prior to recognizing any such appointment of an authorized representative, the Claims Administrator may require proof that the representative has been duly appointed.

Section D3.03 Claims Decisions. Surency will act as Claims Administrator with respect to any Claims for benefits under this DCAP. Surency has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit Claims. Except as otherwise provided by law, all decisions of the Claims Administrator shall be final and binding.

Section D3.04 Electronic Payment Card Reimbursements. If the funds in a DCAP are accessible by electronic debit card, a Participant must comply with the substantiation and correction procedures in accordance with Rev. Rul. 2003-43 and other IRS guidance. A debit card that is presented as payment for a dependent care expense and denied at the point-of-sale (i.e., when the service is provided) does not constitute an initial Claim denial under these procedures.

Section D3.05 Limitation on Reimbursements with Respect to Certain Participants. No more than twenty-five percent (25%) of the total amounts reimbursed from all dependent care assistance accounts maintained by all Participants under this DCAP during any Plan Year may be reimbursed with respect to the class of individuals who own more than five percent (5%) of the stock of the Employer (or their Spouses or dependents). Notwithstanding any other provision of this DCAP, the Claims Administrator may limit the amounts reimbursed with

respect to any Participant who is a highly compensated employee (within the meaning of Code § 414(g)) to the extent the Claims Administrator deems such limitation to be advisable to assure compliance with the restriction described in the preceding sentence or with any nondiscrimination provision of the Code. Such limitation may be imposed whether or not it results in a forfeiture under Section D2.08 above.

Section D3.06 Time Frame for Deciding Claims. The Claim for reimbursement shall be approved or denied within a reasonable period (but no later than ninety (90) days) after receipt of the Claim by the Claims Administrator. The initial 90-day period begins at the time the Claim is filed, whether or not all the necessary information for determining the Claim is provided at that time.

Section D3.07 Extension of Time Frame for Deciding Claims. Notwithstanding Section D3.06 above, if the Claims Administrator determines that special circumstances require an extension of time (up to ninety (90) days from the end of the initial 90-day period) for processing the Claim for reimbursement, written notice of the extension shall be furnished to the Participant before the end of the initial 90-day period. The written notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

Section D3.08 Notification Regarding the Claim Decision. If any Claim for reimbursement of expenses under this DCAP is denied, in whole or in part, then the Claims Administrator shall furnish the Participant written notice within the applicable time periods described in D3.06 or D3.07 above:

(a) Setting forth the reason for the denial;

(b) Making reference to pertinent DCAP provisions upon which the denial is based;

(c) Describing any additional material or information from the Participant which is necessary and why; and

(d) Explaining the Claim review procedure and the applicable time frames set forth herein.

Section D3.09 Right to Appeal the Decision. Within sixty (60) days after receipt of the notification of the denial to reimburse an expense, the Participant may request, in writing, a review of the denial by the Claims Administrator.

Section D3.10 Time Frame for Deciding Appeal. Subject to D3.11 below, the Claims Administrator shall render a decision on review of a denied Claim within a reasonable period of time, but no later than sixty (60) days after receipt of the request for review hereunder unless special circumstances require an extension of time.

This 60-day period begins at the time an Appeal is filed without regard to whether all the information necessary to determine on review whether an expense is reimbursable accompanies the filing. However, if an extension is required, as described below, due to the

Participant's failure to submit necessary information, the period of time for making the determination shall be tolled from the date on which the notification of extension is sent to the Participant until the date on which the Participant responds to the request.

Section D3.11 60-Day Extension of Time. If the Claims Administrator determines that special circumstances require an extension of time (up to sixty (60) days from the end of the initial 60-day period) for processing the Claim, written notice shall be furnished to the Participant before the end of the initial 60-day period. The written notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on Appeal.

Section D3.12 Decision on Appeal. In the case of an adverse decision on Appeal, the Claims Administrator shall send the Participant a notification:

(a) Setting forth the reason for the denial;

(b) Making reference to pertinent DCAP provisions upon which the denial is based;

(c) Stating the Participant 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; and

(d) Explaining any voluntary Appeals procedures and the Participant's right to information regarding these procedures, if any.

ARTICLE D-IV
TERMINATION OF DEPENDENT CARE ASSISTANCE PLAN

Section D4.01 Termination of Participation.

(a) *General Rule.* A Participant will cease participation in this DCAP on the earlier of the following dates:

(i) The date on which this DCAP terminates; or

(ii) The date on which the Participant ceases to be an Eligible Employee.

Although a Participant's participation under this DCAP terminates on the above date, coverage or benefits under the Pre-Tax Benefits may continue if, and to the extent, provided by such Pre-Tax Benefits.

(b) *Effect of Ceasing Participation*. If a Participant ceases to participate in this DCAP for any reason, the Participant's election to receive reimbursements for Qualified Dependent Care Expenses terminates on that date. A Participant may receive reimbursement only for Qualified Dependent Care Expenses incurred within the same DCAP Year and only during the period that the Participant was a

Participant in this DCAP. If a Participant ceases participation under this DCAP, the Participant must apply for reimbursement in accordance with Article D-III within the 30-day period following the date the Participant ceases to be a Participant.

(c) *Electronic Payment Card.* A Participant will not be authorized to continue use of an electronic payment card, such as a debit card, to access funds in his/her DCAP, effective the date of his/her termination from employment. Any claim submitted following a Participant's termination must be submitted in paper form.

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APPENDIX E
VISION PLAN

This Appendix E contains the terms and conditions specific to the USD #262 Valley Center Vision Plan that may be elected under Section 4.01 of the Plan. Unless otherwise altered by the terms of this Appendix E, the terms and conditions of the Plan are incorporated into, and made applicable to, this Vision Plan.

Section E1.01 Eligibility/Plan Entry Dates. The eligibility conditions and the Vision Plan entry dates are the same as those for the Plan.

Section E1.02 Vision Benefits. Benefits under this Vision Plan are identical to those described in, and shall be paid pursuant to the terms of, the Group Contract ("Surency Life and Health Group Contract") between Surency Life and Health ("Surency") and the Employer (Group No. 52110010/52109010). The provisions of that contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by Surency. The Employer makes no promise, and shall have no obligation, to provide or pay such benefits from its own assets. The rights and conditions with respect to the benefits payable under this Vision Plan shall be determined from the Surency Group Contract. The Participant shall bear fully any and all risk of Surency's insolvency.

Section E1.03 Cost of Coverage. The Participant's monthly premiums are determined pursuant to the Surency Group Contract. Under the terms of the Group Contract, Surency may change the premiums from time to time. The Participant must pay the cost of the monthly premium for coverage on a pre-tax basis. The Employer will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant.

Section E1.04 Election to Participate. A Participant who desires to receive vision insurance coverage under this Vision Plan must elect to participate in this Vision Plan and must make arrangements to pay his/her share of the applicable premium. If a Participant does not elect to receive vision coverage under this Vision Plan, the Employer will not provide him/her with any vision insurance coverage.

Section E1.05 Payment of Premium. A Participant who has elected to participate in this Vision Plan may pay the applicable premium on a pre-tax basis by entering into a salary reduction agreement pursuant to the terms and provisions of the Plan. Except for those Participants who are (a) exercising their right to continuation coverage pursuant to Section E1.06 below, (b) exercising their right to continue coverage during a qualifying unpaid leave pursuant to Section 3.03, or (c) eligible pursuant to Section 2.12(b), all premiums must be paid through pre-tax salary reductions.

Section E1.06 Continuation of Coverage. An individual who will lose coverage under this Vision Plan may have the right to continue coverage under this Vision Plan as described in Article VIII.

Section E1.07 Children Subject to a NMSN. Children who are the subject of a National Medical Support Notice ("NMSN") shall become "alternate recipients" of benefits under this Vision Plan in accordance with such order. The Plan Administrator shall establish reasonable procedures to determine the qualified status of a NMSN. Upon receiving a NMSN, the Plan Administrator shall promptly follow the instructions on such NMSN.

Section E1.08 Claims Administration. Surency will act as Claims Administrator with respect to any claim for benefits under this Vision Plan. Surency has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the Group Contract. Except as provided by law, all decisions of the Claims Administrator shall be final and binding.

Section E1.09 Termination of Participation. A Participant ceases to be a Participant as of the earliest of the following:

(a) The last effective date of coverage – as specified by the insurance Group Contract – following the Participant's termination of employment with the Employer;

(b) The date on which the Participant's election to participate expires;

(c) The end of a period for which a required contribution by the Participant was last paid, taking into account any grace periods required by law;

(d) The last effective date of coverage – as specified by the insurance Group Contract – following the date on which the Participant ceases to be an Eligible Employee; or

(e) The date on which this Vision Plan terminates.

Notwithstanding anything in this Section to the contrary, an individual who would normally be required to terminate participation may continue to be a Participant in this Vision Plan if and to the extent such individual elects continuation of benefits under the rules in Section E1.06.

Section E1.10 Character of Benefits Provided. This Vision Plan does not provide vision treatment or advice. It merely pays for the cost of selected benefits as described in, and in accordance with, the provisions of the Group Contract. The fact that a particular vision service may not be eligible for reimbursement under this Vision Plan does not mean that a Participant or other person who is covered under this Vision Plan should not receive that service.

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APPENDIX F
GROUP LIFE PLAN

This Appendix F contains the terms and conditions specific to the USD #262 Valley Center Group Life Plan provided under Section 4.03 of the Plan. Unless otherwise altered by the terms of this Appendix F, the terms and conditions of the Plan are incorporated into, and made applicable to, this Group Life Plan.

Section F1.01 Eligibility/Plan Entry Dates. The eligibility conditions and the Group Life Plan entry dates are the same as those for the Plan.

Section F1.02 Group Life Insurance. Life insurance benefits under this Group Life Plan are identical to those described in, and shall be paid pursuant to the terms of, the Group Contract ("Lincoln Financial Group Contract") between Lincoln Financial ("Lincoln") and the Employer (Group No. 000010133119). The provisions of that contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by Lincoln. The Employer makes no promise, and shall have no obligation, to provide or pay such benefits from its own assets. The rights and conditions, with respect to the benefits payable under this Group Life Plan, shall be determined from the Lincoln Group Contract. The Participant shall bear fully any and all risk of Lincoln's insolvency.

Section F1.03 Cost of Coverage. The Participant's monthly premiums are determined pursuant to the Lincoln Group Contract. Under the terms of the Group Contract, Lincoln may change the premiums from time to time. The Employer will pay one hundred percent (100%) of the monthly premium cost.

Section F1.04 Entry into the Group Life Plan. An Eligible Employee shall automatically become a Participant in this Group Life Plan on the date the Eligible Employee becomes a Participant in the Plan. An election to participate in this Group Life Plan is neither necessary nor required.

Section F1.05 Claims Administration. Lincoln will act as Claims Administrator with respect to any Claim for benefits under this Group Life Plan. Lincoln has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit Claims in accordance with the terms of the Lincoln Group Contract. Except as otherwise provided by law, all decisions of the Claims Administrator shall be final and binding.

Section F1.06 Termination of Participation. A Participant ceases to be a Participant as of the earliest of the following:

(a) The last effective date of coverage – as specified by the insurance Group Contract – following the Participant's termination of employment with the Employer;

(b) The last effective date of coverage – as specified by the insurance Group Contract – following the date on which the Participant ceases to be an Eligible Employee; or

(c) The date on which this Group Life Plan terminates.

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APPENDIX G
VOLUNTARY LIFE PLAN

This Appendix G contains the terms and conditions specific to the USD #262 Valley Center Voluntary Life Plan that may be elected under Section 4.02 of the Plan. Unless otherwise altered by the terms of this Appendix G, the terms and conditions of the Plan are incorporated into, and made applicable to, this Voluntary Life Plan.

Section G1.01 Eligibility/Plan Entry Dates. The eligibility conditions and the Voluntary Life Plan entry dates are the same as those for the Plan.

Section G1.02 Voluntary Life Benefits. Voluntary Life benefits under this Voluntary Life Plan are identical to those described in, and shall be paid pursuant to the terms of, the Group Contract ("Lincoln Financial Group Contract") between Lincoln Financial ("Lincoln") and the Employer (Group No. 000400001000-1373). The provisions of that group contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by Lincoln. The Employer makes no promise and shall have no obligation to provide or pay such benefits from its own assets. The rights and conditions with respect to the benefits payable under this Voluntary Life Plan shall be determined from the Lincoln Group Contract. The Participant shall bear fully any and all risk of Lincoln's insolvency.

Section G1.03 Cost of Coverage. The Participant's monthly premiums are determined pursuant to the Lincoln Group Contract. Under the terms of the Group Contract, Lincoln may change the premiums from time to time. The Participant must pay the cost of the monthly premium for coverage on an after-tax basis. The Employer will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant.

Section G1.04 Election to Participate. A Participant who desires to receive voluntary life coverage under this Voluntary Life Plan must elect to participate in this Voluntary Life Plan and must make arrangements to pay his/her share of the applicable premium. If a Participant does not elect to receive voluntary life coverage under this Voluntary Life Plan, the Employer will not provide him/her with any voluntary life coverage.

Section G1.05 Payment of Premium. A Participant who has elected to participate in this Voluntary Life Plan may pay the applicable premium on an after-tax basis by authorizing a payroll deduction in the amount of the applicable premium.

Section G1.06 Claims Administration. Lincoln will act as Claims Administrator with respect to any Claim for benefits under this Voluntary Life Plan. Lincoln has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit Claims in accordance with the terms of the Lincoln Group Contract. Except as otherwise provided by law, all decisions of the Claims Administrator shall be final and binding.

Section G1.07 Termination of Participation. A Participant ceases to be a Participant as of the earliest of the following:

(a) The last effective date of coverage – as specified by the insurance Group Contract – following the Participant's termination of employment with the Employer;

(b) The date on which the Participant's election to participate expires;

(c) The end of a period for which a required contribution by the Participant was last paid, taking into account any grace periods required by law;

(d) The last effective date of coverage – as specified by the insurance Group Contract – following the date on which the Participant ceases to be an Eligible Employee; or

(e) The date on which this Voluntary Life Plan terminates.

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APPENDIX H
SHORT TERM DISABILITY PLAN

This Appendix H contains the terms and conditions specific to the USD #262 Valley Center Short Term Disability Plan that may be elected under Section 4.02 of the Plan. Unless otherwise altered by the terms of this Appendix H, the terms and conditions of the Plan are incorporated into, and made applicable to, this Short Term Disability Plan.

Section H1.01 Eligibility/Plan Entry Dates. The eligibility conditions and the Short Term Disability Plan entry dates are the same as those for the Plan.

Section H1.02 Short Term Disability Benefits. Short term disability benefits under this Short Term Disability Plan are identical to those described in, and shall be paid pursuant to the terms of, the Group Contract ("Lincoln Financial Group Contract") between Lincoln Financial ("Lincoln") and the Employer (Group No. 000010147074). The provisions of that Group Contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by Lincoln. The Employer makes no promise and shall have no obligation to provide or pay such benefits from its own assets. The rights and conditions with respect to the benefits payable under this Short Term Disability Plan shall be determined from the Lincoln Group Contract. The Participant shall bear fully any and all risk of Lincoln's insolvency.

Section H1.03 Cost of Coverage. The Participant's monthly premiums are determined pursuant to the Lincoln Group Contract. Under the terms of the Group Contract, Lincoln may change the premiums from time to time. The Participant must pay the cost of the monthly premium for coverage on an after-tax basis. The Employer will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant.

Section H1.04 Election to Participate. A Participant who desires to receive short term disability coverage under this Short Term Disability Plan must elect to participate in this Short Term Disability Plan and must make arrangements to pay his/her share of the applicable premium. If a Participant does not elect to receive short term disability coverage under this Short Term Disability Plan, the Employer will not provide him/her with any short term disability coverage.

Section H1.05 Payment of Premium. A Participant who has elected to participate in this Short Term Disability Plan may pay the applicable premium on an after-tax basis by authorizing a payroll deduction in the amount of the applicable premium.

Section H1.06 Claims Administration. Lincoln will act as Claims Administrator with respect to any Claim for benefits under this Short Term Disability Plan. Lincoln has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit Claims in accordance with the terms of the Lincoln Group Contract. Except as otherwise provided by law, all decisions of the Claims Administrator shall be final and binding.

Section H1.07 Termination of Participation. A Participant ceases to be a Participant as of the earliest of the following:

(a) The last effective date of coverage – as specified by the insurance Group Contract – following the Participant's termination of employment with the Employer;

(b) The date on which the Participant's election to participate expires;

(c) The end of a period for which a required contribution by the Participant was last paid, taking into account any grace periods required by law;

(d) The last effective date of coverage – as specified by the insurance Group Contract – following the date on which the Participant ceases to be an Eligible Employee; or

(e) The date on which this Short Term Disability Plan terminates.

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The Lincoln National Life Insurance Company

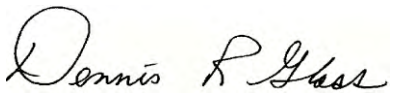
A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066 (402) 361-7300

CERTIFIES THAT Group Policy No. GL 000010147074 has been issued to
USD 262 Valley Center Schools
(The Group Policyholder)

The Issue Date of the Policy is October 1, 2011.

Certificate of Insurance for Class 1

You are entitled to the benefits described in this Certificate only if you are eligible, become and remain insured under the provisions of the Policy. This Certificate replaces any other certificates for the benefits described inside. As a Certificate of Insurance, it is not a contract of insurance; it only summarizes the provisions of the Policy and is subject to the Policy's terms. If the provisions of this Certificate and the Policy do not agree, the provisions of the Policy will apply.



President

CERTIFICATE OF GROUP INSURANCE
PROVIDING
WEEKLY DISABILITY INCOME INSURANCE

USD 262 Valley Center Schools
000010147074

SCHEDULE OF INSURANCE

CLASS 1

All Full-Time Employees Electing a 15/15/26 benefit

WAITING PERIOD: None (For date insurance begins, refer to "Effective Dates" section)

MINIMUM HOURS: 20 hours per week

WEEKLY DISABILITY INCOME INSURANCE

BENEFIT PERCENTAGE: 66 2/3%

MAXIMUM WEEKLY BENEFIT: $1,730

MINIMUM WEEKLY BENEFIT: 10% of your Weekly Total Disability Benefit

MAXIMUM BENEFIT PERIOD: 26 weeks

DAY BENEFITS BEGIN: 15th consecutive day of Disability due to accidental Injury; and
15th consecutive day of Disability due to Sickness.

ADDITIONAL FEATURES:

Family Income Benefit: 3 times your last Weekly Benefit payable immediately prior to death.

Rehabilitation Assistance Benefit:

- Rehabilitation Incentive Benefit of 5% of Basic Weekly Earnings
- Reasonable Accommodation Benefit
- Vocational Rehabilitation Benefit

The Day Benefits Begin may be reached by days of Total Disability, Partial Disability, or any combination thereof.

The Maximum Weekly Benefit will not exceed the Benefit Percentage times Basic Weekly Earnings.

After the Day Benefits Begin, the Maximum Benefit Period will be reduced by any days for which you receive payment under the Employer's Sick Leave or Salary Continuance Plan for the same Disability.

Weekly Disability Income Insurance will terminate when you retire.

The Policy does not replace or provide benefits required by Workers' Compensation laws or any state disability insurance plan laws.

CONTRIBUTIONS: You are required to contribute to the cost of the Weekly Disability Income Insurance.

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DEFINITIONS

As used throughout the Policy, the following terms shall have the meanings indicated below. Other parts of the Policy contain definitions specific to those provisions.

ACTIVE WORK or ACTIVELY AT WORK means your performance of all Main Duties of your Own Occupation, for the regularly scheduled number of hours, at:

(1) the Employer's place of business; or
(2) any other business location where the Employer requires you to travel.

Unless disabled on the prior workday or on the day of absence, you will be considered Actively at Work on the following days:

(1) a Saturday, Sunday or holiday that is not a scheduled workday;
(2) a paid vacation day, or other scheduled or unscheduled non-workday; or
(3) a non-medical leave of absence of 12 weeks or less, whether taken with the Employer's prior approval or on an emergency basis.

This includes a Military Leave or an approved Family or Medical Leave that is not due to your own health condition.

BASIC WEEKLY EARNINGS or **PREDISABILITY INCOME** means your average weekly base salary or hourly pay from the Employer before taxes on the Determination Date. The **"Determination Date"** is the last day worked just prior to the date the Disability begins.

It does **not** include commissions, bonuses, overtime pay, or any other extra compensation. It does **not** include income from a source other than the Employer. It will not exceed the amount shown in the Employer's financial records, the amount for which premium has been paid, or the Maximum Covered Weekly Earnings permitted by the Policy; whichever is less. (Maximum Covered Weekly Earnings equals the Maximum Weekly Benefit divided by the Benefit Percentage shown in the Schedule of Insurance.) Exception: For purposes of determining the Partial Disability Weekly Benefit, Basic Weekly Earnings will not exceed the amount shown in the Employer's financial records.

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

DAY or **DATE** means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, standard time, at the Group Policyholder's place of business. When used with regard to effective dates, it means 12:01 a.m. When used with regard to termination dates, it means 12:00 midnight.

DISABILITY or DISABLED means Total Disability or Partial Disability.

DISABILITY BENEFIT, when used with the term Retirement Plan, means a benefit that:
(1) is payable under a Retirement Plan due to disability as defined in that plan; and
(2) does not reduce the benefits that would have been paid as Retirement Benefits at the normal retirement age under the plan if the disability had not occurred.

If the payment of the benefit does cause such a reduction, the benefit will be deemed a Retirement Benefit as defined in the Policy.

EMPLOYEE or FULL-TIME EMPLOYEE means a person:
(1) whose employment with the Employer is the person's main occupation;
(2) whose employment is for regular wage or salary;
(3) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Insurance per week;
(4) who is a member of an Eligible Class which is eligible for coverage under the Policy;
(5) who is not a temporary or seasonal employee; and
(6) who is a citizen of the United States or legally works in the United States.

EMPLOYER means the Group Policyholder. It includes any division, subsidiary or affiliated company named in the Application or Participation Agreement.

EVIDENCE OF INSURABILITY means a statement of proof of your medical history. The Company uses this to determine your acceptance for insurance or an increased amount of insurance. Such proof will be provided at your own expense.

FAMILY OR MEDICAL LEAVE means an approved leave of absence that:
(1) is subject to the federal FMLA law (the Family and Medical Leave Act of 1993 and any amendments to it) or a similar state law;
(2) is taken in accord with the Employer's leave policy and the law which applies; and
(3) does not exceed the period approved by the Employer and required by that law.

Under the federal FMLA law, such leaves are permitted for up to 12 weeks in a 12-month period as defined by the Employer. The 12 weeks:
(1) may consist of consecutive or intermittent work days; or
(2) may be granted on a part-time equivalency basis.

If you are entitled to a leave under both the federal FMLA law and a similar state law, you may elect the more favorable leave (but not both). If you are on an FMLA leave due to your own health condition on the date Policy coverage takes effect, you are not considered Actively at Work.

FULL-TIME, as it applies to the Partial Disability Benefit, means the average number of hours you were regularly scheduled to work, at your Own Occupation, during the week just prior to:
(1) the date Disability begins; or
(2) the date an approved leave of absence begins, if Disability begins while you are continuing coverage during a leave of absence.

GROUP POLICYHOLDER means the person, company, trust or other organization as shown on the Title Page of the Policy.

INJURY means bodily Injury which results directly from an accident, independently of all other causes. In determining Weekly Benefits, a Disability will be considered caused by a Sickness if:
(1) the Disability begins more than 60 days after the Injury; or
(2) the Injury occurred before your Effective Date under the Policy.

The term "Injury" shall not include any:
(1) condition to which a Sickness, its natural progression or its treatment is a substantial contributing cause (based upon the preponderance of medical evidence);
(2) condition caused by emotional stress or trauma; infection (except pyogenic bacterial infection of an Injury); or medical or surgical treatment (except when needed solely for an Injury);
(3) repetitive trauma condition which results from repetitious, physically traumatic activities that occur over time; or
(4) pregnancy; except for complications that result from an Injury.

INSURANCE MONTH or **POLICY MONTH** means that period of time:
(1) beginning at 12:01 a.m. Standard Time, at the Group Policyholder's place of business on the first day of any calendar month; and
(2) ending at 12:00 midnight on the last day of the same calendar month.

INSURED PERSON means a Person for whom Policy coverage is in effect.

MAIN DUTIES or **MATERIAL AND SUBSTANTIAL DUTIES** means those job tasks that:
(1) are normally required to perform your Own Occupation; and
(2) could not reasonably be modified or omitted.

To determine whether a job task could reasonably be modified or omitted, the Company will apply the Americans with Disabilities Act's standards concerning reasonable accommodation. It will apply the Act's standards, whether or not:
(1) the Employer is subject to the Act; or
(2) you have requested such a job accommodation.
An Employer's failure to modify or omit other job tasks does **not** render you unable to perform the Main Duties of the job.

Main Duties include those job tasks:
(1) as described in the U.S. Department of Labor Dictionary of Occupational Titles; and
(2) as performed in the general labor market and national economy.
Main Duties are **not** limited to those specific job tasks as performed for a certain firm or at a certain work site.

MEDICALLY APPROPRIATE TREATMENT means diagnostic services, consultation, care or services that are consistent with the symptoms or diagnosis causing your Disability. Such treatment must be rendered:
(1) by a Physician whose license and any specialty are consistent with the disabling condition; and
(2) according to generally accepted, professionally recognized standards of medical practice.

MILITARY LEAVE means a leave of absence that:
(1) is subject to the federal USERRA law (the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it);
(2) is taken in accord with the Employer's leave policy and the federal USERRA law; and
(3) does not exceed the period required by that law.

OWN OCCUPATION or **REGULAR OCCUPATION** means the occupation, trade or profession:
(1) in which you were employed with the Employer prior to Disability; and
(2) which was your main source of earned income prior to Disability.

It means a collective description of related jobs, as defined by the U.S. Department of Labor Dictionary of Occupational Titles. It includes any work in the same occupation for pay or profit, regardless of:
(1) whether such work is with the Employer, with some other firm, or on a self-employed basis; or
(2) whether a suitable opening is currently available with the Employer or in the local labor market.

PARTIAL DISABILITY or **PARTIALLY DISABLED** means that, due to an Injury or Sickness, you:
(1) are unable to perform one or more of the Main Duties of your Own Occupation, or are unable to perform such duties Full-Time; and
(2) are engaged in Partial Disability Employment.

PARTIAL DISABILITY EMPLOYMENT means you are working at your Own Occupation or any other occupation; however, because of a Partial Disability:
(1) your hours or production is reduced;
(2) one or more Main Duties of the job are reassigned; or
(3) you are working in a lower-paid occupation.

During Partial Disability Employment, your current earnings:
(1) must be at least 20% of Predisability Income; and
(2) may not exceed the percentage specified in the Partial Disability Benefit section.

PERSON means an Employee of the Employer:
(1) who is a member of an Employee class which is eligible for coverage under the Policy; and
(2) who has completed an enrollment form.

PERSONAL INSURANCE means the insurance provided by the Policy on Insured Persons.

PHYSICIAN means:
(1) a legally qualified medical doctor who is licensed to practice medicine, to prescribe and administer drugs, or to perform surgery; or
(2) any other duly licensed medical practitioner who is deemed by state law to be the same as a legally qualified medical doctor.

The medical doctor or other medical practitioner must be acting within the scope of his or her license. He or she must be qualified to provide Medically Appropriate Treatment for your disabling condition.

Physician does **not** include you or your relatives. Relatives include:
(1) your spouse, siblings, parents, children and grandparents; and
(2) your spouse's relatives of like degree.

POLICY means the group insurance Policy issued by the Company to the Group Policyholder.

PREDISABILITY INCOME--See Basic Weekly Earnings definition.

REGULAR CARE OF A PHYSICIAN means you:
(1) personally visit a Physician, as often as medically required according to standard medical practice to effectively manage and treat your disabling condition; and
(2) receive Medically Appropriate Treatment, by a Physician whose license and any specialty are consistent with the disabling condition.

REGULAR OCCUPATION--See Own Occupation or Regular Occupation definition.

RETIREMENT BENEFIT, when used with the term Retirement Plan, means a benefit that:
(1) is payable under a Retirement Plan either in a lump sum or in the form of periodic payments;
(2) does not represent contributions made by you (Payments representing Employee contributions are deemed to be received over your expected remaining life, regardless of when they are actually received.); and
(3) is payable upon:
    (a) early or normal retirement; or
    (b) disability (if the payment does reduce the benefit which would have been paid at the normal retirement age under the plan, if disability had not occurred).

RETIREMENT PLAN means a defined benefit or defined contribution plan that:
(1) provides Retirement Benefits to Employees; and
(2) is not funded wholly by Employee contributions.

The term shall not include any 401(k), profit-sharing or thrift plan; informal salary continuance plan; individual retirement account (IRA); tax sheltered annuity (TSA); stock ownership plan; or a non-qualified plan of deferred compensation.

An Employer's Retirement Plan is deemed to include any Retirement Plan:
(1) which is part of any federal, state, county, municipal or association retirement system; and
(2) for which you are eligible as a result of employment with the Employer.

SICK LEAVE or **SALARY CONTINUANCE PLAN** means a plan that:

(1) is established and maintained by the Employer for the benefit of Employees; and
(2) continues payment of all or part of your Predisability Income for a specified period after you become Disabled.

It does **not** include compensation the Employer pays you for work actually performed during a Disability.

SICKNESS means illness, pregnancy or disease.

TOTAL DISABILITY or **TOTALLY DISABLED** means your inability, due to Sickness or Injury, to perform each of the Main Duties of your Own Occupation. A Person engaging in any employment for wage or profit is not Totally Disabled. The loss of a professional license, an occupational license or certification, or a driver's license for any reason does **not**, by itself, constitute Total Disability.

WAITING PERIOD means the period of time you must be employed in an eligible class with the Employer, before you become eligible to enroll for coverage under the Policy. The period of service must be continuous, except as explained in the Eligibility provision captioned Prior Service Credit Towards Waiting Period.

WEEKLY BENEFIT means the amount payable weekly by the Company to you while you are Totally Disabled or Partially Disabled.

WORKERS' COMPENSATION OR SIMILAR COVERAGE means coverage under a law that compensates for job related Injury or Sickness. It includes (but is not limited to):

(1) coverage under any Workers' Compensation or occupational disease law;
(2) coverage under the Jones Act; the Longshoreman's and Harbor Worker's Act; the Maritime Doctrine of Maintenance, Wages or Cure; or
(3) any plan provided in place of one of those plans.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties shall consist of:
(1) the Policy and any amendments to it;
(2) the Group Policyholder's application (a copy of which is attached to the Policy);
(3) any Participating Employers' applications or Participation Agreements; and
(4) any individual applications of Insured Persons.

In the absence of fraud, all statements made by the Group Policyholder and by Insured Persons are representations and not warranties. No statement made by an Insured Person will be used to contest the coverage provided by the Policy, unless:
(1) it is contained in a written statement signed by that Insured Person; and
(2) a copy of the statement has been furnished to that Insured Person.

Only an Officer of the Company may change this Policy or extend the time for payment of any premium. No change will be valid unless made in writing and signed by an Officer of the Company. Any change so made will be binding on all persons referred to in the Policy.

INCONTESTABILITY. Except for the non-payment of premiums or fraud, the Company may not contest the validity of the Policy after it has been in force for two years from its date of issue; and as to any Insured Person, after his or her coverage has been in force for two years during his or her lifetime. This clause does not preclude, at any time, the assertion of defenses based upon:
(1) the Policy's eligibility requirements, exclusions and limitations; and
(2) other Policy provisions unrelated to the validity of coverage.

RESCISSION. The Company has the right to rescind any insurance for which Evidence of Insurability was required, if:
(1) you incur a claim during the first two years of coverage; and
(2) the Company discovers that you made a Material Misrepresentation on your application.

A **"Material Misrepresentation"** is an incomplete or untrue statement that caused the Company to issue coverage that it would have disapproved, had it known the truth. No misrepresentation is material unless the statement misrepresented actually contributes to the contingency or event on which the coverage is to become due and payable. **"To rescind"** means to cancel insurance back to its effective date. In that event, the Company will refund all premium paid for the rescinded insurance, less any benefits paid for your claims. The Company reserves the right to recover any claims paid in excess of such premiums.

MISSTATEMENTS OF FACTS. If relevant facts about any Person were misstated:
(1) a fair adjustment of the premium will be made; and
(2) the true facts will decide if and in what amount insurance is valid under the Policy.
If your age has been misstated, any benefits shall be in the amount the paid premium would have purchased at the correct age.

GROUP POLICYHOLDER'S AGENCY. For all purposes of the Policy, the Group Policyholder acts on its own behalf or as an agent of the Insured Person. Under no circumstances will the Group Policyholder be deemed the agent of the Company.

CURRENCY. In administering the Policy:
(1) all Predisability Income will be expressed in U.S. dollars; and
(2) all premium and benefits must be paid in U.S. dollars.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE. The Policy does not replace or provide benefits required by:
(1) Workers' Compensation laws; or
(2) any state temporary disability insurance plan laws.

ASSIGNMENT. The rights and benefits under this Certificate may not be assigned.

ELIGIBILITY AND EFFECTIVE DATES

ELIGIBLE CLASSES. The classes of Employees eligible for insurance are shown in the Schedule of Insurance. The Company has the right to review and terminate any or all classes eligible under the Policy, if any class ceases to be covered by the Policy.

ELIGIBILITY. A Person becomes eligible for coverage provided by the Policy on the later of:
(1) the Policy's date of issue; or
(2) the date the Waiting Period is completed.

Prior Service Credit Towards Waiting Period. The Waiting Period is shown in the Schedule of Insurance. Prior service in an Eligible Class will apply toward the Waiting Period, when:
(1) you are a former Employee and are rehired within one year after your employment ends;
(2) you return from an approved Family or Medical Leave within:
  (a) the 12-week period required by federal law; or
  (b) any longer period required by a similar state law; or
(3) you return from a Military Leave within the period required by federal USERRA law.

EFFECTIVE DATE. Your initial amount of Personal Insurance becomes effective at 12:01 a.m. on the latest of:
(1) the first day of the Insurance Month following the date you become eligible for the coverage;
(2) the date you resume Active Work, if not Actively at Work on the day you become eligible;
(3) the date you make written application for coverage and sign:
  (a) a payroll deduction order, if you pay any part of the Policy premiums; or
  (b) an order to pay premiums from your Flexible Benefits Plan account, if Employer contributions are made through such an account; or
(4) the date the Company approves your Evidence of Insurability, if required.

Any increased or additional coverage becomes effective at 12:01 a.m. on the latest of:
(1) the first day of the Insurance Month coinciding with or next following the day on which you become eligible for the increase, if Actively at Work on that day;
(2) the date you resume Active Work, if not Actively at Work on the day the increase would otherwise take effect; or
(3) the date any required Evidence of Insurability is approved by the Company.

Any decrease will take effect on the day of the change, whether or not you are Actively at Work.

Evidence of Insurability. Evidence of Insurability satisfactory to the Company must be submitted (at your expense) when:
(1) you make written application for coverage (or an increased amount of coverage) more than 31 days after becoming eligible for the coverage; or
(2) you make written application for coverage after you have requested:
  (a) to cancel insurance;
  (b) to stop payroll deductions for the insurance; or
  (c) to stop premium payments from the Flexible Benefits Plan account.

Effective Date for Change in Eligible Class. You may become a member of a different Eligible Class. Coverage under the different Eligible Class will be effective:
(1) on the first day of the Insurance Month coinciding with or next following the date of the change;
(2) except as stated in the Effective Date provision for increases or decreases.

ELIGIBILITY AND EFFECTIVE DATES
(Continued)

REINSTATEMENT RIGHTS. If your coverage terminates due to one of the following breaks in service, you will be entitled to reinstate the coverage upon resuming Active Work with the Employer within the required timeframe. **"Reinstatement"** or **"to reinstate"** means to re-enroll for Policy coverage, without satisfying a new Waiting Period or providing Evidence of Insurability. Reinstatement is available upon:

(1) return from an approved Family or Medical Leave within:
  (a) the 12-week period required by federal law; or
  (b) any longer period required by a similar state law;
(2) return from a Military Leave within the period required by federal USERRA law;
(3) return from any other approved leave of absence within six months after the leave begins;
(4) return within 12 months following a lay off; or
(5) return within 12 months following termination of employment for any other reason.

To reinstate coverage, you must apply for coverage or be re-enrolled within 31 days after resuming Active Work in an Eligible Class. The reinstated amount of insurance may not exceed the amount that terminated. Reinstatement will take effect on the date you return to Active Work.

If the above conditions are met, and the Policy includes a Pre-Existing Condition Exclusion, then:

(1) the months of leave will count towards any unmet Pre-Existing Condition Exclusion period; and
(2) a new Pre-Existing Condition Exclusion will not apply to the reinstated amount of insurance.

A new Pre-Existing Condition Exclusion will apply to any increased amount of insurance.

INDIVIDUAL TERMINATIONS

TERMINATION OF COVERAGE. Your coverage will terminate at 12:00 midnight on the earliest of:

(1) the date the Policy terminates or the Employer's participation ends (but without prejudice to any claim incurred prior to termination);
(2) the date your class is no longer eligible for insurance;
(3) the date you cease to be a member of an Eligible Class;
(4) the last day of the Insurance Month in which you request termination;
(5) the last day of the last Insurance Month for which premium payment is made on your behalf;
(6) the end of the period for which the last required premium has been paid;
(7) with respect to any particular insurance benefit, the day the portion of the Policy providing that benefit terminates;
(8) the date your employment with the Group Policyholder or Participating Employer terminates (unless coverage is continued as provided below); or
(9) the date you enter the armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard. (If you send proof of military service, the Company will refund any unearned premium.)

CONTINUATION RIGHTS. Ceasing Active Work results in termination of your eligibility for coverage, but coverage may be continued as follows.

Disability. If you are absent due to Total Disability or engaged in Partial Disability Employment, coverage may be continued:

(1) until the Day Benefits Begin; and
(2) during the period for which benefits are payable.

The Company must receive the required premium from the Employer.

INDIVIDUAL TERMINATIONS
(Continued)

Family or Medical Leave. If you go on an approved Family or Medical Leave and are **not** entitled to the more favorable continuation available during Disability, coverage may be continued until the earliest of:

(1) the end of the leave period approved by the Employer;
(2) the end of the 12-week leave period required by federal law, or any more favorable period required by a similar state law;
(3) the date you notify the Employer that you will not return; or
(4) the date you begin employment with another employer.

The required premium payments must be received from the Employer, throughout the period of continued coverage.

Military Leave. If you go on a Military Leave, coverage may be continued for the same period allowed for an approved Family or Medical Leave. The required premium payments must be received from the Employer, throughout the period of continued coverage.

Lay Off or Other Leave. If you cease work due to a temporary lay off, or due to an approved leave of absence (other than an approved Family or Medical Leave or a Military Leave); coverage may be continued for three Insurance Months after the lay off or leave begins. The required premium payments must be received from the Employer, throughout the period of continued coverage.

Conditions. In administering the above continuations, the Employer must not act so as to discriminate unfairly among Insured Persons in similar situations. Insurance may **not** be continued when you cease Active Work due to a labor dispute, strike, work slowdown or lockout.

INDIVIDUAL TERMINATION DURING DISABILITY. Termination of your coverage during a Disability will have no effect on benefits payable for that period of Disability.

CLAIMS PROCEDURES
FOR WEEKLY DISABILITY INCOME BENEFITS

NOTICE AND PROOF OF CLAIM -- Notice of Claim. Written notice of a Disability claim must be given:
(1) within 20 days after the Injury or Sickness causing Disability begins; or
(2) as soon as reasonably possible after that.*
The notice must be sent to the Company's Group Insurance Service Office. It should include your name and address, and the number of the Policy.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days, you may send the Company written proof of Disability in a letter. It should state the date the Disability began, its cause and degree. The Company will periodically send you additional claim forms.

Proof of Claim. The Company must be given written proof of a Disability claim:
(1) within 90 days after the Day Benefits Begin; or
(2) as soon as reasonably possible after that.*

Proof of claim must be provided at your own expense. It must show the date the Disability began, its cause and degree. Documentation must include the following:
(1) completed statements by you and your Employer;
(2) a completed statement by the attending Physician, which must describe any restrictions on the performance of the duties of your Regular Occupation;
(3) proof of any other income received, and of any other benefits available from other income sources, which may affect Policy benefits;
(4) a signed authorization for the Company to obtain more information; and
(5) any other items the Company may reasonably require in support of the claim.

Proof of continued Disability, Regular Care of a Physician, and any Other Income Benefits affecting the claim must be given to the Company. This must be supplied within 45 days after the Company requests it. If it is not, benefits may be denied or suspended.

***Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim, if it is shown that it was done:
(1) as soon as reasonably possible; and
(2) in no event more than one year after it was required.
These time limits will not apply while you lack legal capacity.

EXAMINATION. The Company may have you examined:
(1) by a Physician, specialist or vocational rehabilitation expert of the Company's choice;
(2) as often as reasonably required while a claim or appeal is pending.

Any such exam will be at the Company's expense.

The Company may determine that (in its opinion) you have:
(1) failed to cooperate with an examiner;
(2) failed to take an exam scheduled by the Company; or
(3) postponed such an exam more than twice.
In that event, benefits may be denied or suspended, until the required exam is completed.

CLAIMS PROCEDURES
(Continued)

TIME OF PAYMENT OF CLAIMS. Weekly Disability Income Benefits payable under the Policy will be paid immediately after the Company receives complete proof of claim and confirms liability. Such benefits will be paid biweekly, during any period for which the Company is liable. If benefits are due for less than a week, they will be paid on a pro rata basis. The daily rate will equal 1/7 of the Weekly Benefit. Any balance, which remains unpaid at the end of the period of liability, will be paid immediately after the Company receives complete proof of claim and confirms liability.

TO WHOM PAYABLE. All Weekly Disability Income Benefits are payable to you, while living. After your death, such benefits will be payable to your estate.

NOTICE OF CLAIM DECISION. The Company will send you a written notice of its claim decision. If the Company denies any part of the claim, the written notice will explain:

(1) the reason for the denial, under the terms of the Policy and any internal guidelines;
(2) how you may request a review of the Company's decision; and
(3) whether more information is needed to support the claim.

This notice will be sent within 15 days after the Company resolves the claim. It will be sent within 45 days after the Company receives the first proof of claim, if reasonably possible.

Delay Notice. The Company may need more than 15 days to process the claim, due to matters beyond its control. If so, an extension will be permitted. In that event, the Company will send you a written delay notice:

(1) by the 15th day after receiving the first proof of claim; and
(2) every 30 days after that, until the claim is resolved.

The notice will explain:

(1) what additional information is needed to determine liability; and
(2) when a decision can be expected.

If you do not receive a written decision by the 105th day after the Company receives the first proof of claim, there is a right to an immediate review, as if the claim was denied.

Exception: The Company may need more information from you to process a claim. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. Within 180 days after receiving a denial notice, you may request a claim review by sending the Company:

(1) a written request; and
(2) any written comments or other items to support the claim.

You may review certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send you a written notice of its decision. The notice will state the reasons for the Company's decision, under the terms of the Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim, the notice will also describe:

(1) any further appeal procedures available under the Policy;
(2) the right to access relevant claim information; and
(3) the right to request a state insurance department review, or to bring legal action.

This notice will be sent within 45 days after the Company receives the request for review, or within 90 days if a special case requires more time.

Delay Notice. If the Company needs more than 45 days to process an appeal, in a special case:
(1) an extension of up to 45 more days will be permitted; and
(2) the Company will send you a written delay notice, by the 30th day after receiving the request for review.

The notice will explain:
(1) the special circumstances which require the delay;
(2) whether more information is needed to review the claim; and
(3) when a decision can be expected.

Exception: The Company may need more information from you to process an appeal. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under the Policy, the plan participant or beneficiary must first seek two administrative reviews of the adverse claim decision, in accord with this section. After the required reviews:
(1) an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
(2) the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

ERRORS RELATED TO THE INSURED PERSON'S COVERAGE. The Company has the right to correct benefit payments that are made in error. You, your Beneficiary or your estate has the responsibility to return any overpayments to the Company. The Company has the responsibility to make additional payments, if any underpayments have been made.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than five years after the date written proof of claim is required.

COMPANY'S DISCRETIONARY AUTHORITY. Except for the functions that the Policy clearly reserves to the Group Policyholder or Employer, the Company has the authority to manage the Policy, interpret its provisions, administer claims and resolve questions arising under it. The Company's authority includes (but is not limited to) the right to:
(1) establish administrative procedures, determine eligibility and resolve claims questions;
(2) determine what information the Company reasonably requires to make such decisions; and
(3) resolve all matters when an internal claim review is requested.

You have a right to request a state insurance department review or to bring legal action.
This provision does not apply to residents of California.

WEEKLY DISABILITY INCOME INSURANCE

TOTAL DISABILITY BENEFIT. The Company will pay a Weekly Total Disability Benefit for each week the Total Disability continues, if you:

(1) become Totally Disabled while insured for this benefit;
(2) are under the Regular Care of a Physician; and
(3) at your own expense, submit proof of continued Total Disability and Physician's care to the Company upon request.

Duration. Benefits start on the Day Benefits Begin, and end on the earliest of:

(1) the date you cease to be Totally Disabled or die;
(2) the date the Maximum Benefit Period ends; or
(3) the date you are able, but choose not to engage in Partial Disability Employment in your Own Occupation.

Proportional benefits will be paid for a partial week of Total Disability.

At the Company's option, benefits may also be denied or suspended on any of the following dates:

(1) the date you (without good cause):
    (a) fail to take a required medical exam;
    (b) fail to cooperate with an examiner; or
    (c) postpone a required exam more than twice;
(2) the 45th day after the Company requests additional proof, if not given; or
(3) the 45th day after the Company requests proof of your application for any Other Income Benefits to which you may be entitled (and which affect Policy benefits); if not given.

Amount. The amount of the Weekly Total Disability Benefit equals:

(1) your Basic Weekly Earnings multiplied by the Benefit Percentage (limited to the Maximum Weekly Benefit); minus
(2) Other Income Benefits.

The amount of the Weekly Total Disability Benefit will not be less than the Minimum Weekly Benefit, unless the Minimum Weekly Benefit plus Other Income Benefits would exceed 100% of your Basic Weekly Earnings.

The Day Benefits Begin, Maximum Benefit Period, Benefit Percentage, Maximum Weekly Benefit, and Minimum Weekly Benefit are shown in the Schedule of Insurance.

PARTIAL DISABILITY BENEFIT. The Company will pay a Weekly Partial Disability Benefit, if you:

(1) become Partially Disabled while insured for this benefit;
(2) are engaged in Partial Disability Employment;
(3) are earning at least 20% of Basic Weekly Earnings when Partial Disability Employment begins;
(4) are under the Regular Care of a Physician; and
(5) at your own expense, submit proof of continued Partial Disability, Physician's care and reduced earnings to the Company upon request.

You are not required to be Totally Disabled prior to receiving Weekly Partial Disability Benefits. The Day Benefits Begin may be reached by days of Total Disability, Partial Disability, or any combination of these. Proportional benefits will be paid for a partial week of Partial Disability.

Duration. Benefits start on the Day Benefits Begin, and will cease on the earliest of:

(1) the date you cease to be Partially Disabled or die;
(2) the date the Maximum Benefit Period ends;
(3) the date you earn more than 99% of Basic Weekly Earnings; or
(4) the date you are able, but choose not to work Full-Time or part-time in your Own Occupation.

At the Company's option, benefits may also be denied or suspended on any of the following dates:

(1) the date you (without good cause):
  (a) fail to take a required medical exam;
  (b) fail to cooperate with an examiner; or
  (c) postpone a required exam more than twice;
(2) the 45th day after the Company requests additional proof, if not given; or
(3) the 45th day after the Company requests proof of your application for Other Income Benefits to which you may be entitled (and which affect Policy benefits); if not given.

Amount. The amount of the Weekly Partial Disability Benefit equals the lesser of A or B below:

(A) (1) Your Basic Weekly Earnings multiplied by the Benefit Percentage (limited to the Maximum Weekly Benefit); minus
  (2) Other Income Benefits, except for earnings you receive from Partial Disability Employment; or
(B) Your Basic Weekly Earnings minus Other Income Benefits.

The amount of the Weekly Partial Disability Benefit will not be less than the Minimum Weekly Benefit, unless the Minimum Weekly Benefit plus Other Income Benefits would exceed 100% of your Basic Weekly Earnings.

The Day Benefits Begin, Maximum Benefit Period, Benefit Percentage, Maximum Weekly Benefit, and Minimum Weekly Benefit are shown in the Schedule of Insurance.

OTHER INCOME BENEFITS means Earnings, benefits, awards, or settlements from the following sources. These amounts will be offset, in determining your Weekly Benefit. Except for Retirement Benefits and Earnings, these amounts must result from the same Disability for which a Weekly Benefit is payable under the Policy.

Compulsory Benefits. Any disability income benefits you are eligible to receive under:
(1) state temporary disability income benefit laws;
(2) state no fault auto insurance laws; or
(3) any other compulsory benefit act or law (except Workers' Compensation and laws of like intent).

Other Insurance Plans. Any disability income benefits for which you are eligible under any no fault auto plan.

Employer's Retirement Plan. Any Disability Benefits or Retirement Benefits you receive under the Employer's Retirement Plan.

Social Security and other Government Retirement Plans. The following Social Security or other Government Retirement Plan benefits will be offset:
(1) **disability benefits** for which you and any spouse or child is eligible, because of your Disability;
(2) **unreduced retirement benefits** for which you and any spouse or child is eligible, because of your eligibility for unreduced retirement benefits; or
(3) **reduced retirement benefits** actually received by you and any spouse or child, because of your receipt of reduced retirement benefits.

As used above, **"Government Retirement Plans"** include disability and retirement benefits under:
(1) the federal Social Security Act, Jones Act or Railroad Retirement Act;
(2) the Canada Pension Plan or Quebec Pension Plan;
(3) any similar plan or act of any country, state, province or other political unit; or
(4) any plan provided in place of one of the above plans.

"Earnings", as used in this provision, means pay you earn or receive from any occupation or form of employment, as reported for federal income tax purposes. Earnings include (but are not limited to) a:
(1) salaried or hourly Employee's gross earnings (shown on Form W-2); including:
  (a) wages, tips, commissions, bonuses and overtime pay; and
  (b) any pre-tax contributions to a Section 125 Plan, flexible spending account, or qualified deferred compensation plan;
(2) proprietor's net profit (figured from Form 1040, Schedule C);
(3) professional corporation shareholder's net profit (figured from Form 1040, Schedule C);
(4) partner's net earnings from self-employment (shown on Schedule K-1) and any W-2 earnings; and
(5) Subchapter S Corporation shareholder's net earnings from trade or business activities (shown on Schedule K-1).

Recovery from Third Party. Any amount you recover from a third party as a result of the Disability (whether by judgment, settlement or otherwise). The offset:

(1) will be reduced by attorney fees and other reasonable costs of recovery; and
(2) will not exceed 100% of the net settlement.

Exceptions. The following will **not** be considered Other Income Benefits, and will not be offset in determining the Weekly Benefit:

(1) a cost-of-living increase in any Other Income Benefit (except Earnings); if it takes effect after the first offset for that benefit during a period of Disability;
(2) reimbursement for hospital, medical or surgical expense;
(3) reimbursement for attorney fees or other reasonable costs of claiming Other Income Benefits;
(4) group credit or mortgage disability insurance;
(5) early retirement benefits that are not elected or received under the federal Social Security Act or other Government Retirement Plan;
(6) any amounts under the Employer's Retirement Plan that:
    (a) represent your contributions; or
    (b) are received upon termination of employment without being disabled or retired;
(7) benefits from a 401(k), profit-sharing or thrift plan; an individual retirement account (IRA); a tax sheltered annuity (TSA); a stock ownership plan; or a non-qualified plan of deferred compensation;
(8) vacation pay, holiday pay, or severance pay; or
(9) disability income benefits under any individual policy, association group plan, franchise plan, or auto liability insurance policy (except no fault auto insurance).

RULES CONCERNING OTHER INCOME BENEFITS. If you may be entitled to Other Income Benefits that affect Policy benefits, you are required to actively claim them. For example, if Social Security or other Government Retirement Plan benefits may be payable, you:

(1) must promptly apply for such benefits; and, if denied
(2) must file an appeal or request an administrative hearing, upon Company request.

If you fail to promptly pursue such benefits, the Company has the option to deny or suspend Weekly Benefits or to reduce them by an estimated amount.

If Workers' Compensation or similar benefits may be payable for the same Disability, you and your Employer are required to cooperate in filing for those benefits. The Company will require proof of the denial or duration of those benefits to confirm its liability under the Policy.

Refunding Overpayments. Upon receiving Other Income Benefits, you must refund any resulting overpayment of Weekly Benefits under the Policy. If you do not promptly refund an overpayment to the Company within 60 days, in a lump sum, then:

(1) the Company will reduce or eliminate future payments; and
(2) the Minimum Weekly Benefit will not apply, until the amount is repaid.

Cost of Living Freeze. After the first deduction for each of the Other Income Benefits (except Earnings), its amount will be frozen. The Weekly Benefit will not be further reduced due to any cost-of-living increases payable under these Other Income Benefits.

RECURRENT DISABILITY. "Recurrent Disability" means a Disability caused by an Injury or Sickness which is the same as, or related to, the cause of a prior Disability for which Weekly Benefits were payable.

(1) A Recurrent Disability will be treated as a new period of Disability, if you:
   (a) have returned to your Own Occupation; and
   (b) have worked on a full-time basis, for two consecutive weeks or more.
   A new Day Benefits Begin and new Maximum Benefit Period will apply.

(2) A Recurrent Disability will be treated as part of the prior Disability, if you:
   (a) have returned to your Own Occupation; and
   (b) have worked on a full-time basis, for less than two consecutive weeks.
   The same Day Benefits Begin and same Maximum Benefit Period will apply to the Recurrent Disability as to the prior Disability.

To qualify for a Weekly Benefit for a Recurrent Disability, you must earn less than the percentage of Predisability Income specified in the Partial Disability Benefit section. Benefit payments will be subject to all other terms of the Policy that applied to the prior Disability.

This Recurrent Disability provision will cease to apply when you become eligible for coverage under any other group short-term disability policy.

EXCLUSIONS. Weekly Benefits will not be payable for any period of Disability:

(1) which is the result of an intentionally self-inflicted Injury or suicide attempt;
(2) during which you are not under the Regular Care of a Physician;
(3) which is the result of war (declared or undeclared) or any act of war;
(4) which is the result of a Sickness or Injury for which you receive benefits under Workers' Compensation or similar coverage;
(5) which arises out of (or in the course of) any employment for wage or profit, when the Disability would be covered by Workers' Compensation or similar coverage if:
   (a) the Employer had enrolled you for such coverage; and
   (b) you and your Employer had cooperated in filing a claim under that plan; or
(6) during which you receive payment under the Employer's Sick Leave or Salary Continuance Plan.

PRE-EXISTING CONDITION LIMITATION. The Policy will not cover any period of Disability:

(1) which is caused or contributed to by, or results from a Pre-Existing Condition; and
(2) which begins in the first 12 months after your Effective Date, unless you received no Treatment of the condition for 12 months in a row after your Effective Date.

"Pre-Existing Condition" means a Sickness or Injury for which you received Treatment within 3 months prior to your Effective Date.

"Treatment" means consultation, care and services by a Physician. It includes diagnostic measures and the prescription, refill and taking of prescribed drugs or medicines.

VOCATIONAL REHABILITATION BENEFIT

BENEFIT. If you are Disabled and are receiving Weekly Benefits under the Policy, you may be eligible for a Vocational Rehabilitation Benefit. This benefit consists of services which may include:

(1) vocational evaluation, counseling, training or job placement;
(2) job modification or special equipment; and
(3) other services which the Company deems reasonably necessary to help you return to work.

The Company will determine your eligibility and the amount of any benefit payable.

ELIGIBILITY. You may be eligible for the Vocational Rehabilitation Benefit if the Company finds that you:

(1) have a Disability that prevents the performance of the Main Duties of your Own Occupation;
(2) have the physical and mental abilities needed to complete a Rehabilitation Program; and
(3) are reasonably expected to return to work after completing the Rehabilitation Program; in view of your degree of motivation and the labor force demand for workers in the proposed occupation.

The Company must also find that the cost of the proposed services is less than its expected claim liability.

AMOUNT. The amount of any Vocational Rehabilitation Benefit will not exceed the Company's expected claims liability. This benefit will not be payable for services covered under your health care plan or any other vocational rehabilitation program. Payment may be made to the provider of the services, at the Company's option.

CONDITIONS. The Company, you, or your Physician may first propose vocational rehabilitation. When a Rehabilitation Program is approved by the Company, the Policy's definition of "Disability" will be waived during the rehabilitation period; however, it will be reapplied after the Rehabilitation Program ends. The Company will determine the amount and duration of any Weekly Disability benefits payable after the Rehabilitation Program ends.

LIMITATION. The Policy will not cover any period of Disability if you have received a Vocational Rehabilitation Benefit and have failed to complete the Rehabilitation Program, without Good Cause.

DEFINITIONS.

"**Good Cause**," as used in this provision, means your:

(1) documented physical or mental impairments, which render you unable to take part in or complete a Rehabilitation Program;
(2) involvement in a medical program, which prevents or interferes with your taking part in or completing a Rehabilitation Program; or
(3) participating in good faith in some other vocational rehabilitation program, which:
    (a) conflicts with taking part in or completing a Rehabilitation Program developed by the Company; and
    (b) is reasonably expected to return you to work.

"**Rehabilitation Program**" means a written vocational rehabilitation program:

(1) which the Company develops with input from:
    (a) you;
    (b) your Physician; and
    (c) any current or prospective employer, when appropriate; and
(2) which describes the Program's goals; each party's responsibilities; and the times, dates and costs of the rehabilitation services.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all the Definitions, Exclusions, Claims Procedures, and other provisions of the Policy.

REHABILITATION INCENTIVE BENEFIT

BENEFIT. The Company will pay you a Rehabilitation Incentive Benefit if you are Totally or Partially Disabled and actively participating in a Rehabilitation Program approved by the Company.

AMOUNT. The amount of the Rehabilitation Incentive Benefit is shown in the Schedule of Insurance.

The Rehabilitation Incentive Benefit is paid in addition to any other Policy benefits, and is not subject to Policy provisions that would otherwise reduce the benefit amount, such as the Other Income Benefits provision.

DURATION. The Rehabilitation Incentive Benefit starts on the latest of:
(1) the date you begin to participate in an approved Rehabilitation Program; or
(2) the date the Company approves your Rehabilitation Program.

The Rehabilitation Incentive Benefit will cease on the earliest of:
(1) the date the Weekly Total or Partial Disability Benefits would otherwise cease under the Policy; or
(2) the date you cease participation in an approved Rehabilitation Program.

DEFINITION.

"**Rehabilitation Program**" means a written vocational rehabilitation program:
(1) which the Company develops with input from:
  (a) you;
  (b) your Physician; and
  (c) any current or prospective employer, when appropriate; and
(2) which describes the Program's goals; each party's responsibilities; and the times, dates and costs of the rehabilitation services.

PROOF. Written proof of active participation in a Rehabilitation Program must be given:
(1) within 90 days after the Day Benefits Begin; or
(2) as soon as reasonably possible after that.

Proof of active participation must be provided at your own expense. The proof must be sent to the Company's Group Insurance Service Office. It should include your name and address and the number of the Policy.

Exception: Failure to furnish proof of active participation in a Rehabilitation Program within the required time period will not invalidate the benefit, if it is shown that it was done:
(1) as soon as reasonably possible; and
(2) in no event more than one year after it was required.

These time limits will not apply while you lack legal capacity.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all the Definitions, Exclusions, Claims Procedures, and other provisions of the Policy.

REASONABLE ACCOMMODATION BENEFIT

BENEFIT. If you are Disabled and are receiving Weekly Benefits under the Policy, then the Group Policyholder may be eligible for a Reasonable Accommodation benefit. This benefit reimburses the Group Policyholder for 50% of the expense incurred for reasonable accommodation services for you, but will not exceed the lesser of:

(1) a maximum benefit of $2500 for any one Insured Person; or
(2) the Company's expected liability for your Weekly Disability Income claim.

Such services may include:

(1) providing you a more accessible parking space or entrance;
(2) removing barriers or hazards to you from the worksite;
(3) special seating, furniture or equipment for your work station;
(4) providing special training materials or translation services during your training; and
(5) other services the Company deems reasonably necessary to help you return to work with the Group Policyholder.

ELIGIBILITY. The Company will determine the Group Policyholder's eligibility to receive the Reasonable Accommodation benefit. To qualify for the Reasonable Accommodation benefit, the Group Policyholder must have an Insured Person:

(1) whose Disability prevents the performance of his or her Own Occupation at the Group Policyholder's worksite;
(2) who has the physical and mental abilities needed to perform his or her Own Occupation or another occupation at the Group Policyholder's worksite, but only with the help of the proposed accommodation; and
(3) who is reasonably expected to return to work with the help of the proposed accommodation.

The Company must also find that the requested Reasonable Accommodation benefit is less than the expected liability for your Weekly Disability Income claim.

WRITTEN PROPOSAL. The reasonable accommodation services must be provided in accord with a written proposal, which is developed with input from:

(1) the Group Policyholder;
(2) you; and
(3) your Physician, when appropriate.

The proposal must state:

(1) the purpose of the proposed accommodation; and
(2) the times, dates, and costs of the services.

CONDITIONS. The Company, the Group Policyholder, you, or your Physician may first propose an accommodation.

The proposal must be approved by the Company in writing.

The Company will reimburse the Group Policyholder upon receipt of proof that the Group Policyholder:

(1) has provided the services for you; and
(2) has paid the provider for the services.

OTHER PROVISIONS. Unless stated otherwise, the Reasonable Accommodation benefit is subject to all the Definitions, Exclusions, Claims Procedures, and other provisions of the Policy.

FAMILY INCOME BENEFIT

BENEFIT. The Company will pay a benefit to the Eligible Survivor(s) when satisfactory written proof is received that you died:

(1) after Disability had continued for at least 14 consecutive days; and
(2) while receiving a Weekly Benefit.

If payment becomes due to your children; then payment will be made to:

(1) the surviving children, in equal shares; or
(2) a person named by the Company to receive payments on the children's behalf.

This payment will be valid and effective against all claims by others representing, or claiming to represent, your children.

If there are no Eligible Survivors, payment will be made to your estate.

AMOUNT. The Family Income Benefit is shown in the Schedule of Insurance. Reductions for Other Income Benefits will not apply.

If any state disability plan compulsory death benefits become payable upon your death, then any Family Income Benefit amount payable will be reduced by such compulsory death benefits.

DEFINITION.

"Eligible Survivor(s)" means your:

(1) surviving spouse; or, if none,
(2) surviving children who are under age 25 on your date of death.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all the Definitions, Exclusions, Claims Procedures, and other provisions of the Policy.

GENERAL PURPOSES AND LIMITATIONS OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION K.S.A.40-3001 et. seq.

DISCLAIMER

THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MAY NOT PROVIDE COVERAGE FOR ALL OR A PORTION OF THIS POLICY. IF COVERAGE IS PROVIDED, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS AND EXCLUSIONS, AND IS CONDITIONED UPON RESIDENCY IN THIS STATE. THEREFORE, YOU SHOULD NOT RELY UPON COVERAGE BY THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELECTING AN INSURANCE COMPANY OR IN SELECTING AN INSURANCE POLICY. INSURANCE COMPANIES AND THEIR AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELLING YOU ANY FORM OF AN INSURANCE POLICY, OR TO INDUCE YOU TO PURCHASE ANY FORM OF AN INSURANCE POLICY. EITHER THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE KANSAS INSURANCE DEPARTMENT WILL RESPOND TO ANY QUESTIONS YOU HAVE REGARDING THIS DOCUMENT.

Kansas Life and Health Insurance
Guaranty Association
2909 SW Maupin Lane
Topeka, KS 66614

Kansas Insurance Department
420 SW 9th Street
Topeka, KS 66612

This is a brief summary of the Kansas Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. If there is any inconsistency between this notice and Kansas law, then Kansas law will control.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Kansas law, with funding from assessments paid by other insurance companies. This safety net was created under Kansas law, which determines who and what is covered and the amounts of coverage. The basic protections provided by the Association are:

- Life Insurance

  $300,000 in death benefits

  $100,000 in cash surrender or withdrawal values

- Health Insurance

  $500,000 in hospital, medical and surgical insurance benefits

  $300,000 in disability insurance benefits

  $300,000 in long-term care insurance benefits

  $100,000 in other types of health insurance benefits

- Annuities

  $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits, as well as certain aggregate limits.

CERTIFICATE AMENDMENT

TO BE ATTACHED TO THE CERTIFICATE FOR GROUP POLICY NO.: 000010147074

ISSUED TO: USD 262 Valley Center Schools

Your Certificate is amended by adding the following provisions.

PRIOR INSURANCE CREDIT UPON TRANSFER OF
DISABILITY INCOME INSURANCE CARRIERS

This provision prevents loss of disability income coverage for you, which could otherwise occur solely because of a transfer of insurance carriers. The Policy will provide the following Prior Insurance Credit, when it replaces a prior plan.

"Prior Plan" means a prior carrier's group disability income policy, which the Policy replaced within 1 day of the prior plan's termination date.

FAILURE TO SATISFY ACTIVE WORK RULE. Subject to premium payments, the Policy will provide disability income coverage if you:

(1) were insured by the prior plan on its termination date; and
(2) were otherwise eligible under the Policy; but were not Actively-At-Work due to Injury or Sickness on its Effective Date.

AMOUNT OF COVERAGE. Until you satisfy the Policy's Active Work rule, your disability income coverage will not exceed that provided by the prior plan, had it remained in force. The Company will pay:

(1) the benefit the prior plan would have paid; minus
(2) any amount for which the prior carrier is liable.

DISABILITY DUE TO A PRE-EXISTING CONDITION. Benefits may be payable for a period of disability due to a Pre-Existing Condition if you:

(1) were insured by the prior plan on its termination date; and
(2) were Actively-At-Work and became insured under the Policy on its Effective Date.

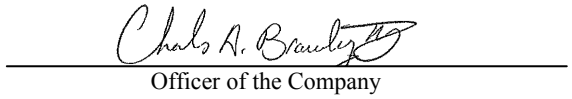
The benefits will be determined as follows:

A. The Company will apply the Policy's Pre-Existing Condition Limitation. If you qualify for benefits, you will be paid according to the Policy's benefit schedule.

B. If you cannot satisfy the Policy's Pre-Existing Condition Limitation; then the prior plan's pre-existing condition limitation will be applied, as follows:
   (1) If you satisfy the prior plan's pre-existing condition limitation, giving consideration towards continuous time insured under both policies; then benefits will be paid according to the prior plan's benefit schedule.
   (2) If you cannot satisfy the Pre-Existing Condition Limitation of the Policy, or that of the prior plan; then no benefit will be paid.

This Amendment takes effect on your effective date of coverage under the Policy. In all other respects, your Certificate remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

Lincoln Financial Group®

LINCOLN FINANCIAL GROUP® PRIVACY PRACTICES NOTICE

The Lincoln Financial Group companies* are committed to protecting your privacy. To provide the products and services you expect from a financial services leader, we must collect personal information about you. **We do not sell your personal information to third parties.** We share your personal information with third parties as necessary to provide you with the products or services you request and to administer your business with us. This Notice describes our current privacy practices. While your relationship with us continues, we will update and send our Privacy Practices Notice as required by law. Even after that relationship ends, we will continue to protect your personal information. **You do not need to take any action because of this Notice, but you do have certain rights as described below.**

INFORMATION WE MAY COLLECT AND USE

We collect personal information about you to help us identify you as our customer or our former customer; to process your requests and transactions; to offer investment or insurance services to you; to pay your claim; or to tell you about our products or services we believe you may want and use. The type of personal information we collect depends on the products or services you request and may include the following:

- **Information from you**: When you submit your application or other forms, you give us information such as your name, address, Social Security number; and your financial, health, and employment history.

- **Information about your transactions**: We keep information about your transactions with us, such as the products you buy from us; the amount you paid for those products; your account balances; and your payment history.

- **Information from outside our family of companies**: If you are purchasing insurance products, we may collect information from consumer reporting agencies such as your credit history; credit scores; and driving and employment records. With your authorization, we may also collect information, such as medical information from other individuals or businesses.

- **Information from your employer**: If your employer purchases group products from us, we may obtain information about you from your employer in order to enroll you in the plan.

HOW WE USE YOUR PERSONAL INFORMATION

We may share your personal information within our companies and with certain service providers. They use this information to process transactions you have requested; provide customer service; and inform you of products or services we offer that you may find useful. Our service providers may or may not be affiliated with us. They include financial service providers (for example, third party administrators; broker-dealers; insurance agents and brokers, registered representatives; reinsurers and other financial services companies with whom we have joint marketing agreements). Our service providers also include non-financial companies and individuals (for example, consultants; vendors; and companies that perform marketing services on our behalf). Information we obtain from a report prepared by a service provider may be kept by the service provider and shared with other persons; however, we require our service providers to protect your personal information and to use or disclose it only for the work they are performing for us, or as permitted by law.

When you apply for one of our products, we may share information about your application with credit bureaus. We also may provide information to group policy owners, regulatory authorities and law enforcement officials and to others when we believe in good faith that the law requires disclosure. In the event of a sale of all or part of our businesses, we may share customer information as part of the sale. **We do not sell or share your information with outside marketers who may want to offer you their own products and services; nor do we share information we receive about you from a consumer reporting agency. You do not need to take any action for this benefit.**

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

SECURITY OF INFORMATION

We have an important responsibility to keep your information safe. We use safeguards to protect your information from unauthorized disclosure. Our employees are authorized to access your information only when they need it to provide you with products, services, or to maintain your accounts. Employees who have access to your personal information are required to keep it confidential. Employees are trained on the importance of data privacy.

Questions about your personal information should be directed to:

Lincoln Financial Group
Attn: Enterprise Compliance and Ethics
Corporate Privacy Office, 7C-01
1300 S. Clinton St.
Fort Wayne, IN 46802

Please include all policy/contract/account numbers with your correspondence.

*This information applies to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company
Lincoln Financial Group Trust Company, LLC
Lincoln Financial Investment Services Corporation
Lincoln Investment Advisors Corporation
Lincoln Life & Annuity Company of New York
Lincoln Retirement Services Company, LLC
Lincoln Variable Insurance Products Trust
The Lincoln National Life Insurance Company

ADDITIONAL PRIVACY INFORMATION FOR INSURANCE PRODUCT CUSTOMERS

CONFIDENTIALITY OF MEDICAL INFORMATION

We understand that you may be especially concerned about the privacy of your medical information. We do not sell or rent your medical information to anyone; nor do we share it with others for marketing purposes. We only use and share your medical information for the purpose of underwriting insurance, administering your policy or claim and other purposes permitted by law, such as disclosure to regulatory authorities or in response to a legal proceeding.

MAKING SURE MEDICAL INFORMATION IS ACCURATE

We want to make sure we have accurate information about you. Upon written request we will tell you, within 30 business days, what personal information we have about you. You may see a copy of your personal information in person or receive a copy by mail, whichever you prefer. We will share with you who provided the information. In some cases we may provide your medical information to your personal physician. We will not provide you with information we have collected in connection with, or in anticipation of, a claim or legal proceeding. If you believe that any of our records are not correct, you may write and tell us of any changes you believe should be made. We will respond to your request within 30 business days. A copy of your request will be kept on file with your personal information so anyone reviewing your information in the future will be aware of your request. If we make changes to your records as a result of your request, we will notify you in writing and we will send the updated information, at your request, to any person who may have received the information within the prior two years. We will also send the updated information to any insurance support organization that gave us the information, and any service provider that received the information within the prior 7 years.

Questions about your personal medical information should be directed to:

Lincoln Financial Group
Attn: Medical Underwriting
P.O. Box 21008
Greensboro, NC 27420-1008

The CONFIDENTIALITY OF MEDICAL INFORMATION and MAKING SURE INFORMATION IS ACCURATE sections of this Notice apply to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company
Lincoln Life & Annuity Company of New York
The Lincoln National Life Insurance Company

The Lincoln National Life Insurance Company

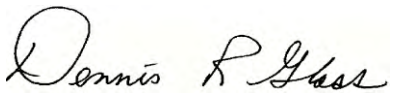
A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066 (402) 361-7300

CERTIFIES THAT Group Policy No. GL 000010147074 has been issued to
USD 262 Valley Center Schools
(The Group Policyholder)

The Issue Date of the Policy is October 1, 2011.

Certificate of Insurance for Class 2

You are entitled to the benefits described in this Certificate only if you are eligible, become and remain insured under the provisions of the Policy. This Certificate replaces any other certificates for the benefits described inside. As a Certificate of Insurance, it is not a contract of insurance; it only summarizes the provisions of the Policy and is subject to the Policy's terms. If the provisions of this Certificate and the Policy do not agree, the provisions of the Policy will apply.



President

CERTIFICATE OF GROUP INSURANCE
PROVIDING
WEEKLY DISABILITY INCOME INSURANCE

USD 262 Valley Center Schools
000010147074

SCHEDULE OF INSURANCE

CLASS 2

All Full-Time Employees Electing a 31/31/26 benefit

WAITING PERIOD: None (For date insurance begins, refer to "Effective Dates" section)

MINIMUM HOURS: 20 hours per week

WEEKLY DISABILITY INCOME INSURANCE

BENEFIT PERCENTAGE: 66 2/3%

MAXIMUM WEEKLY BENEFIT: $1,730

MINIMUM WEEKLY BENEFIT: 10% of your Weekly Total Disability Benefit

MAXIMUM BENEFIT PERIOD: 26 weeks

DAY BENEFITS BEGIN: 31st consecutive day of Disability due to accidental Injury; and
31st consecutive day of Disability due to Sickness.

The Day Benefits Begin may be reached by days of Total Disability, Partial Disability, or any combination thereof.

The Maximum Weekly Benefit will not exceed the Benefit Percentage times Basic Weekly Earnings.

After the Day Benefits Begin, the Maximum Benefit Period will be reduced by any days for which you receive payment under the Employer's Sick Leave or Salary Continuance Plan for the same Disability.

Weekly Disability Income Insurance will terminate when you retire.

The Policy does not replace or provide benefits required by Workers' Compensation laws or any state disability insurance plan laws.

CONTRIBUTIONS: You are required to contribute to the cost of the Weekly Disability Income Insurance.

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DEFINITIONS

As used throughout the Policy, the following terms shall have the meanings indicated below. Other parts of the Policy contain definitions specific to those provisions.

ACTIVE WORK or ACTIVELY AT WORK means your performance of all Main Duties of your Own Occupation, for the regularly scheduled number of hours, at:

(1) the Employer's place of business; or
(2) any other business location where the Employer requires you to travel.

Unless disabled on the prior workday or on the day of absence, you will be considered Actively at Work on the following days:

(1) a Saturday, Sunday or holiday that is not a scheduled workday;
(2) a paid vacation day, or other scheduled or unscheduled non-workday; or
(3) a non-medical leave of absence of 12 weeks or less, whether taken with the Employer's prior approval or on an emergency basis.

This includes a Military Leave or an approved Family or Medical Leave that is not due to your own health condition.

BASIC WEEKLY EARNINGS or **PREDISABILITY INCOME** means your average weekly base salary or hourly pay from the Employer before taxes on the Determination Date. The **"Determination Date"** is the last day worked just prior to the date the Disability begins.

It does **not** include commissions, bonuses, overtime pay, or any other extra compensation. It does **not** include income from a source other than the Employer. It will not exceed the amount shown in the Employer's financial records, the amount for which premium has been paid, or the Maximum Covered Weekly Earnings permitted by the Policy; whichever is less. (Maximum Covered Weekly Earnings equals the Maximum Weekly Benefit divided by the Benefit Percentage shown in the Schedule of Insurance.) Exception: For purposes of determining the Partial Disability Weekly Benefit, Basic Weekly Earnings will not exceed the amount shown in the Employer's financial records.

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

DAY or **DATE** means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, standard time, at the Group Policyholder's place of business. When used with regard to effective dates, it means 12:01 a.m. When used with regard to termination dates, it means 12:00 midnight.

DISABILITY or DISABLED means Total Disability or Partial Disability.

DISABILITY BENEFIT, when used with the term Retirement Plan, means a benefit that:
(1) is payable under a Retirement Plan due to disability as defined in that plan; and
(2) does not reduce the benefits that would have been paid as Retirement Benefits at the normal retirement age under the plan if the disability had not occurred.

If the payment of the benefit does cause such a reduction, the benefit will be deemed a Retirement Benefit as defined in the Policy.

EMPLOYEE or FULL-TIME EMPLOYEE means a person:
(1) whose employment with the Employer is the person's main occupation;
(2) whose employment is for regular wage or salary;
(3) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Insurance per week;
(4) who is a member of an Eligible Class which is eligible for coverage under the Policy;
(5) who is not a temporary or seasonal employee; and
(6) who is a citizen of the United States or legally works in the United States.

EMPLOYER means the Group Policyholder. It includes any division, subsidiary or affiliated company named in the Application or Participation Agreement.

EVIDENCE OF INSURABILITY means a statement of proof of your medical history. The Company uses this to determine your acceptance for insurance or an increased amount of insurance. Such proof will be provided at your own expense.

FAMILY OR MEDICAL LEAVE means an approved leave of absence that:
(1) is subject to the federal FMLA law (the Family and Medical Leave Act of 1993 and any amendments to it) or a similar state law;
(2) is taken in accord with the Employer's leave policy and the law which applies; and
(3) does not exceed the period approved by the Employer and required by that law.

Under the federal FMLA law, such leaves are permitted for up to 12 weeks in a 12-month period as defined by the Employer. The 12 weeks:
(1) may consist of consecutive or intermittent work days; or
(2) may be granted on a part-time equivalency basis.

If you are entitled to a leave under both the federal FMLA law and a similar state law, you may elect the more favorable leave (but not both). If you are on an FMLA leave due to your own health condition on the date Policy coverage takes effect, you are not considered Actively at Work.

FULL-TIME, as it applies to the Partial Disability Benefit, means the average number of hours you were regularly scheduled to work, at your Own Occupation, during the week just prior to:
(1) the date Disability begins; or
(2) the date an approved leave of absence begins, if Disability begins while you are continuing coverage during a leave of absence.

GROUP POLICYHOLDER means the person, company, trust or other organization as shown on the Title Page of the Policy.

INJURY means bodily Injury which results directly from an accident, independently of all other causes. In determining Weekly Benefits, a Disability will be considered caused by a Sickness if:
(1) the Disability begins more than 60 days after the Injury; or
(2) the Injury occurred before your Effective Date under the Policy.

The term "Injury" shall not include any:
(1) condition to which a Sickness, its natural progression or its treatment is a substantial contributing cause (based upon the preponderance of medical evidence);
(2) condition caused by emotional stress or trauma; infection (except pyogenic bacterial infection of an Injury); or medical or surgical treatment (except when needed solely for an Injury);
(3) repetitive trauma condition which results from repetitious, physically traumatic activities that occur over time; or
(4) pregnancy; except for complications that result from an Injury.

INSURANCE MONTH or **POLICY MONTH** means that period of time:
(1) beginning at 12:01 a.m. Standard Time, at the Group Policyholder's place of business on the first day of any calendar month; and
(2) ending at 12:00 midnight on the last day of the same calendar month.

INSURED PERSON means a Person for whom Policy coverage is in effect.

MAIN DUTIES or **MATERIAL AND SUBSTANTIAL DUTIES** means those job tasks that:
(1) are normally required to perform your Own Occupation; and
(2) could not reasonably be modified or omitted.

To determine whether a job task could reasonably be modified or omitted, the Company will apply the Americans with Disabilities Act's standards concerning reasonable accommodation. It will apply the Act's standards, whether or not:
(1) the Employer is subject to the Act; or
(2) you have requested such a job accommodation.
An Employer's failure to modify or omit other job tasks does **not** render you unable to perform the Main Duties of the job.

Main Duties include those job tasks:
(1) as described in the U.S. Department of Labor Dictionary of Occupational Titles; and
(2) as performed in the general labor market and national economy.
Main Duties are **not** limited to those specific job tasks as performed for a certain firm or at a certain work site.

MEDICALLY APPROPRIATE TREATMENT means diagnostic services, consultation, care or services that are consistent with the symptoms or diagnosis causing your Disability. Such treatment must be rendered:
(1) by a Physician whose license and any specialty are consistent with the disabling condition; and
(2) according to generally accepted, professionally recognized standards of medical practice.

MILITARY LEAVE means a leave of absence that:
(1) is subject to the federal USERRA law (the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it);
(2) is taken in accord with the Employer's leave policy and the federal USERRA law; and
(3) does not exceed the period required by that law.

OWN OCCUPATION or **REGULAR OCCUPATION** means the occupation, trade or profession:
(1) in which you were employed with the Employer prior to Disability; and
(2) which was your main source of earned income prior to Disability.

It means a collective description of related jobs, as defined by the U.S. Department of Labor Dictionary of Occupational Titles. It includes any work in the same occupation for pay or profit, regardless of:
(1) whether such work is with the Employer, with some other firm, or on a self-employed basis; or
(2) whether a suitable opening is currently available with the Employer or in the local labor market.

PARTIAL DISABILITY or **PARTIALLY DISABLED** means that, due to an Injury or Sickness, you:
(1) are unable to perform one or more of the Main Duties of your Own Occupation, or are unable to perform such duties Full-Time; and
(2) are engaged in Partial Disability Employment.

PARTIAL DISABILITY EMPLOYMENT means you are working at your Own Occupation or any other occupation; however, because of a Partial Disability:
(1) your hours or production is reduced;
(2) one or more Main Duties of the job are reassigned; or
(3) you are working in a lower-paid occupation.

During Partial Disability Employment, your current earnings:
(1) must be at least 20% of Predisability Income; and
(2) may not exceed the percentage specified in the Partial Disability Benefit section.

PERSON means an Employee of the Employer:
(1) who is a member of an Employee class which is eligible for coverage under the Policy; and
(2) who has completed an enrollment form.

PERSONAL INSURANCE means the insurance provided by the Policy on Insured Persons.

PHYSICIAN means:
(1) a legally qualified medical doctor who is licensed to practice medicine, to prescribe and administer drugs, or to perform surgery; or
(2) any other duly licensed medical practitioner who is deemed by state law to be the same as a legally qualified medical doctor.

The medical doctor or other medical practitioner must be acting within the scope of his or her license. He or she must be qualified to provide Medically Appropriate Treatment for your disabling condition.

Physician does **not** include you or your relatives. Relatives include:
(1) your spouse, siblings, parents, children and grandparents; and
(2) your spouse's relatives of like degree.

POLICY means the group insurance Policy issued by the Company to the Group Policyholder.

PREDISABILITY INCOME--See Basic Weekly Earnings definition.

REGULAR CARE OF A PHYSICIAN means you:
(1) personally visit a Physician, as often as medically required according to standard medical practice to effectively manage and treat your disabling condition; and
(2) receive Medically Appropriate Treatment, by a Physician whose license and any specialty are consistent with the disabling condition.

REGULAR OCCUPATION--See Own Occupation or Regular Occupation definition.

RETIREMENT BENEFIT, when used with the term Retirement Plan, means a benefit that:
(1) is payable under a Retirement Plan either in a lump sum or in the form of periodic payments;
(2) does not represent contributions made by you (Payments representing Employee contributions are deemed to be received over your expected remaining life, regardless of when they are actually received.); and
(3) is payable upon:
    (a) early or normal retirement; or
    (b) disability (if the payment does reduce the benefit which would have been paid at the normal retirement age under the plan, if disability had not occurred).

RETIREMENT PLAN means a defined benefit or defined contribution plan that:
(1) provides Retirement Benefits to Employees; and
(2) is not funded wholly by Employee contributions.

The term shall not include any 401(k), profit-sharing or thrift plan; informal salary continuance plan; individual retirement account (IRA); tax sheltered annuity (TSA); stock ownership plan; or a non-qualified plan of deferred compensation.

An Employer's Retirement Plan is deemed to include any Retirement Plan:
(1) which is part of any federal, state, county, municipal or association retirement system; and
(2) for which you are eligible as a result of employment with the Employer.

SICK LEAVE or **SALARY CONTINUANCE PLAN** means a plan that:

(1) is established and maintained by the Employer for the benefit of Employees; and
(2) continues payment of all or part of your Predisability Income for a specified period after you become Disabled.

It does **not** include compensation the Employer pays you for work actually performed during a Disability.

SICKNESS means illness, pregnancy or disease.

TOTAL DISABILITY or **TOTALLY DISABLED** means your inability, due to Sickness or Injury, to perform each of the Main Duties of your Own Occupation. A Person engaging in any employment for wage or profit is not Totally Disabled. The loss of a professional license, an occupational license or certification, or a driver's license for any reason does **not**, by itself, constitute Total Disability.

WAITING PERIOD means the period of time you must be employed in an eligible class with the Employer, before you become eligible to enroll for coverage under the Policy. The period of service must be continuous, except as explained in the Eligibility provision captioned Prior Service Credit Towards Waiting Period.

WEEKLY BENEFIT means the amount payable weekly by the Company to you while you are Totally Disabled or Partially Disabled.

WORKERS' COMPENSATION OR SIMILAR COVERAGE means coverage under a law that compensates for job related Injury or Sickness. It includes (but is not limited to):

(1) coverage under any Workers' Compensation or occupational disease law;
(2) coverage under the Jones Act; the Longshoreman's and Harbor Worker's Act; the Maritime Doctrine of Maintenance, Wages or Cure; or
(3) any plan provided in place of one of those plans.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties shall consist of:
(1) the Policy and any amendments to it;
(2) the Group Policyholder's application (a copy of which is attached to the Policy);
(3) any Participating Employers' applications or Participation Agreements; and
(4) any individual applications of Insured Persons.

In the absence of fraud, all statements made by the Group Policyholder and by Insured Persons are representations and not warranties. No statement made by an Insured Person will be used to contest the coverage provided by the Policy, unless:
(1) it is contained in a written statement signed by that Insured Person; and
(2) a copy of the statement has been furnished to that Insured Person.

Only an Officer of the Company may change this Policy or extend the time for payment of any premium. No change will be valid unless made in writing and signed by an Officer of the Company. Any change so made will be binding on all persons referred to in the Policy.

INCONTESTABILITY. Except for the non-payment of premiums or fraud, the Company may not contest the validity of the Policy after it has been in force for two years from its date of issue; and as to any Insured Person, after his or her coverage has been in force for two years during his or her lifetime. This clause does not preclude, at any time, the assertion of defenses based upon:
(1) the Policy's eligibility requirements, exclusions and limitations; and
(2) other Policy provisions unrelated to the validity of coverage.

RESCISSION. The Company has the right to rescind any insurance for which Evidence of Insurability was required, if:
(1) you incur a claim during the first two years of coverage; and
(2) the Company discovers that you made a Material Misrepresentation on your application.

A **"Material Misrepresentation"** is an incomplete or untrue statement that caused the Company to issue coverage that it would have disapproved, had it known the truth. No misrepresentation is material unless the statement misrepresented actually contributes to the contingency or event on which the coverage is to become due and payable. **"To rescind"** means to cancel insurance back to its effective date. In that event, the Company will refund all premium paid for the rescinded insurance, less any benefits paid for your claims. The Company reserves the right to recover any claims paid in excess of such premiums.

MISSTATEMENTS OF FACTS. If relevant facts about any Person were misstated:
(1) a fair adjustment of the premium will be made; and
(2) the true facts will decide if and in what amount insurance is valid under the Policy.
If your age has been misstated, any benefits shall be in the amount the paid premium would have purchased at the correct age.

GROUP POLICYHOLDER'S AGENCY. For all purposes of the Policy, the Group Policyholder acts on its own behalf or as an agent of the Insured Person. Under no circumstances will the Group Policyholder be deemed the agent of the Company.

CURRENCY. In administering the Policy:
(1) all Predisability Income will be expressed in U.S. dollars; and
(2) all premium and benefits must be paid in U.S. dollars.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE. The Policy does not replace or provide benefits required by:
(1) Workers' Compensation laws; or
(2) any state temporary disability insurance plan laws.

ASSIGNMENT. The rights and benefits under this Certificate may not be assigned.

ELIGIBILITY AND EFFECTIVE DATES

ELIGIBLE CLASSES. The classes of Employees eligible for insurance are shown in the Schedule of Insurance. The Company has the right to review and terminate any or all classes eligible under the Policy, if any class ceases to be covered by the Policy.

ELIGIBILITY. A Person becomes eligible for coverage provided by the Policy on the later of:
(1) the Policy's date of issue; or
(2) the date the Waiting Period is completed.

Prior Service Credit Towards Waiting Period. The Waiting Period is shown in the Schedule of Insurance. Prior service in an Eligible Class will apply toward the Waiting Period, when:
(1) you are a former Employee and are rehired within one year after your employment ends;
(2) you return from an approved Family or Medical Leave within:
  (a) the 12-week period required by federal law; or
  (b) any longer period required by a similar state law; or
(3) you return from a Military Leave within the period required by federal USERRA law.

EFFECTIVE DATE. Your initial amount of Personal Insurance becomes effective at 12:01 a.m. on the latest of:
(1) the first day of the Insurance Month following the date you become eligible for the coverage;
(2) the date you resume Active Work, if not Actively at Work on the day you become eligible;
(3) the date you make written application for coverage and sign:
  (a) a payroll deduction order, if you pay any part of the Policy premiums; or
  (b) an order to pay premiums from your Flexible Benefits Plan account, if Employer contributions are made through such an account; or
(4) the date the Company approves your Evidence of Insurability, if required.

Any increased or additional coverage becomes effective at 12:01 a.m. on the latest of:
(1) the first day of the Insurance Month coinciding with or next following the day on which you become eligible for the increase, if Actively at Work on that day;
(2) the date you resume Active Work, if not Actively at Work on the day the increase would otherwise take effect; or
(3) the date any required Evidence of Insurability is approved by the Company.

Any decrease will take effect on the day of the change, whether or not you are Actively at Work.

Evidence of Insurability. Evidence of Insurability satisfactory to the Company must be submitted (at your expense) when:
(1) you make written application for coverage (or an increased amount of coverage) more than 31 days after becoming eligible for the coverage; or
(2) you make written application for coverage after you have requested:
  (a) to cancel insurance;
  (b) to stop payroll deductions for the insurance; or
  (c) to stop premium payments from the Flexible Benefits Plan account.

Effective Date for Change in Eligible Class. You may become a member of a different Eligible Class. Coverage under the different Eligible Class will be effective:
(1) on the first day of the Insurance Month coinciding with or next following the date of the change;
(2) except as stated in the Effective Date provision for increases or decreases.

ELIGIBILITY AND EFFECTIVE DATES
(Continued)

REINSTATEMENT RIGHTS. If your coverage terminates due to one of the following breaks in service, you will be entitled to reinstate the coverage upon resuming Active Work with the Employer within the required timeframe. **"Reinstatement"** or **"to reinstate"** means to re-enroll for Policy coverage, without satisfying a new Waiting Period or providing Evidence of Insurability. Reinstatement is available upon:

(1) return from an approved Family or Medical Leave within:
  (a) the 12-week period required by federal law; or
  (b) any longer period required by a similar state law;
(2) return from a Military Leave within the period required by federal USERRA law;
(3) return from any other approved leave of absence within six months after the leave begins;
(4) return within 12 months following a lay off; or
(5) return within 12 months following termination of employment for any other reason.

To reinstate coverage, you must apply for coverage or be re-enrolled within 31 days after resuming Active Work in an Eligible Class. The reinstated amount of insurance may not exceed the amount that terminated. Reinstatement will take effect on the date you return to Active Work.

If the above conditions are met, and the Policy includes a Pre-Existing Condition Exclusion, then:

(1) the months of leave will count towards any unmet Pre-Existing Condition Exclusion period; and
(2) a new Pre-Existing Condition Exclusion will not apply to the reinstated amount of insurance.

A new Pre-Existing Condition Exclusion will apply to any increased amount of insurance.

INDIVIDUAL TERMINATIONS

TERMINATION OF COVERAGE. Your coverage will terminate at 12:00 midnight on the earliest of:

(1) the date the Policy terminates or the Employer's participation ends (but without prejudice to any claim incurred prior to termination);
(2) the date your class is no longer eligible for insurance;
(3) the date you cease to be a member of an Eligible Class;
(4) the last day of the Insurance Month in which you request termination;
(5) the last day of the last Insurance Month for which premium payment is made on your behalf;
(6) the end of the period for which the last required premium has been paid;
(7) with respect to any particular insurance benefit, the day the portion of the Policy providing that benefit terminates;
(8) the date your employment with the Group Policyholder or Participating Employer terminates (unless coverage is continued as provided below); or
(9) the date you enter the armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard. (If you send proof of military service, the Company will refund any unearned premium.)

CONTINUATION RIGHTS. Ceasing Active Work results in termination of your eligibility for coverage, but coverage may be continued as follows.

Disability. If you are absent due to Total Disability or engaged in Partial Disability Employment, coverage may be continued:

(1) until the Day Benefits Begin; and
(2) during the period for which benefits are payable.

The Company must receive the required premium from the Employer.

INDIVIDUAL TERMINATIONS
(Continued)

Family or Medical Leave. If you go on an approved Family or Medical Leave and are **not** entitled to the more favorable continuation available during Disability, coverage may be continued until the earliest of:

(1) the end of the leave period approved by the Employer;
(2) the end of the 12-week leave period required by federal law, or any more favorable period required by a similar state law;
(3) the date you notify the Employer that you will not return; or
(4) the date you begin employment with another employer.

The required premium payments must be received from the Employer, throughout the period of continued coverage.

Military Leave. If you go on a Military Leave, coverage may be continued for the same period allowed for an approved Family or Medical Leave. The required premium payments must be received from the Employer, throughout the period of continued coverage.

Lay Off or Other Leave. If you cease work due to a temporary lay off, or due to an approved leave of absence (other than an approved Family or Medical Leave or a Military Leave); coverage may be continued for three Insurance Months after the lay off or leave begins. The required premium payments must be received from the Employer, throughout the period of continued coverage.

Conditions. In administering the above continuations, the Employer must not act so as to discriminate unfairly among Insured Persons in similar situations. Insurance may **not** be continued when you cease Active Work due to a labor dispute, strike, work slowdown or lockout.

INDIVIDUAL TERMINATION DURING DISABILITY. Termination of your coverage during a Disability will have no effect on benefits payable for that period of Disability.

CLAIMS PROCEDURES
FOR WEEKLY DISABILITY INCOME BENEFITS

NOTICE AND PROOF OF CLAIM -- Notice of Claim. Written notice of a Disability claim must be given:
(1) within 20 days after the Injury or Sickness causing Disability begins; or
(2) as soon as reasonably possible after that.*
The notice must be sent to the Company's Group Insurance Service Office. It should include your name and address, and the number of the Policy.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days, you may send the Company written proof of Disability in a letter. It should state the date the Disability began, its cause and degree. The Company will periodically send you additional claim forms.

Proof of Claim. The Company must be given written proof of a Disability claim:
(1) within 90 days after the Day Benefits Begin; or
(2) as soon as reasonably possible after that.*

Proof of claim must be provided at your own expense. It must show the date the Disability began, its cause and degree. Documentation must include the following:
(1) completed statements by you and your Employer;
(2) a completed statement by the attending Physician, which must describe any restrictions on the performance of the duties of your Regular Occupation;
(3) proof of any other income received, and of any other benefits available from other income sources, which may affect Policy benefits;
(4) a signed authorization for the Company to obtain more information; and
(5) any other items the Company may reasonably require in support of the claim.

Proof of continued Disability, Regular Care of a Physician, and any Other Income Benefits affecting the claim must be given to the Company. This must be supplied within 45 days after the Company requests it. If it is not, benefits may be denied or suspended.

***Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim, if it is shown that it was done:
(1) as soon as reasonably possible; and
(2) in no event more than one year after it was required.
These time limits will not apply while you lack legal capacity.

EXAMINATION. The Company may have you examined:
(1) by a Physician, specialist or vocational rehabilitation expert of the Company's choice;
(2) as often as reasonably required while a claim or appeal is pending.

Any such exam will be at the Company's expense.

The Company may determine that (in its opinion) you have:
(1) failed to cooperate with an examiner;
(2) failed to take an exam scheduled by the Company; or
(3) postponed such an exam more than twice.
In that event, benefits may be denied or suspended, until the required exam is completed.

CLAIMS PROCEDURES
(Continued)

TIME OF PAYMENT OF CLAIMS. Weekly Disability Income Benefits payable under the Policy will be paid immediately after the Company receives complete proof of claim and confirms liability. Such benefits will be paid biweekly, during any period for which the Company is liable. If benefits are due for less than a week, they will be paid on a pro rata basis. The daily rate will equal 1/7 of the Weekly Benefit. Any balance, which remains unpaid at the end of the period of liability, will be paid immediately after the Company receives complete proof of claim and confirms liability.

TO WHOM PAYABLE. All Weekly Disability Income Benefits are payable to you, while living. After your death, such benefits will be payable to your estate.

NOTICE OF CLAIM DECISION. The Company will send you a written notice of its claim decision. If the Company denies any part of the claim, the written notice will explain:

(1) the reason for the denial, under the terms of the Policy and any internal guidelines;
(2) how you may request a review of the Company's decision; and
(3) whether more information is needed to support the claim.

This notice will be sent within 15 days after the Company resolves the claim. It will be sent within 45 days after the Company receives the first proof of claim, if reasonably possible.

Delay Notice. The Company may need more than 15 days to process the claim, due to matters beyond its control. If so, an extension will be permitted. In that event, the Company will send you a written delay notice:

(1) by the 15th day after receiving the first proof of claim; and
(2) every 30 days after that, until the claim is resolved.

The notice will explain:

(1) what additional information is needed to determine liability; and
(2) when a decision can be expected.

If you do not receive a written decision by the 105th day after the Company receives the first proof of claim, there is a right to an immediate review, as if the claim was denied.

Exception: The Company may need more information from you to process a claim. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. Within 180 days after receiving a denial notice, you may request a claim review by sending the Company:

(1) a written request; and
(2) any written comments or other items to support the claim.

You may review certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send you a written notice of its decision. The notice will state the reasons for the Company's decision, under the terms of the Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim, the notice will also describe:

(1) any further appeal procedures available under the Policy;
(2) the right to access relevant claim information; and
(3) the right to request a state insurance department review, or to bring legal action.

This notice will be sent within 45 days after the Company receives the request for review, or within 90 days if a special case requires more time.

Delay Notice. If the Company needs more than 45 days to process an appeal, in a special case:
(1) an extension of up to 45 more days will be permitted; and
(2) the Company will send you a written delay notice, by the 30th day after receiving the request for review.

The notice will explain:
(1) the special circumstances which require the delay;
(2) whether more information is needed to review the claim; and
(3) when a decision can be expected.

Exception: The Company may need more information from you to process an appeal. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under the Policy, the plan participant or beneficiary must first seek two administrative reviews of the adverse claim decision, in accord with this section. After the required reviews:
(1) an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
(2) the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

ERRORS RELATED TO THE INSURED PERSON'S COVERAGE. The Company has the right to correct benefit payments that are made in error. You, your Beneficiary or your estate has the responsibility to return any overpayments to the Company. The Company has the responsibility to make additional payments, if any underpayments have been made.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than five years after the date written proof of claim is required.

COMPANY'S DISCRETIONARY AUTHORITY. Except for the functions that the Policy clearly reserves to the Group Policyholder or Employer, the Company has the authority to manage the Policy, interpret its provisions, administer claims and resolve questions arising under it. The Company's authority includes (but is not limited to) the right to:
(1) establish administrative procedures, determine eligibility and resolve claims questions;
(2) determine what information the Company reasonably requires to make such decisions; and
(3) resolve all matters when an internal claim review is requested.
You have a right to request a state insurance department review or to bring legal action.
This provision does not apply to residents of California.

WEEKLY DISABILITY INCOME INSURANCE

TOTAL DISABILITY BENEFIT. The Company will pay a Weekly Total Disability Benefit for each week the Total Disability continues, if you:

(1) become Totally Disabled while insured for this benefit;
(2) are under the Regular Care of a Physician; and
(3) at your own expense, submit proof of continued Total Disability and Physician's care to the Company upon request.

Duration. Benefits start on the Day Benefits Begin, and end on the earliest of:

(1) the date you cease to be Totally Disabled or die;
(2) the date the Maximum Benefit Period ends; or
(3) the date you are able, but choose not to engage in Partial Disability Employment in your Own Occupation.

Proportional benefits will be paid for a partial week of Total Disability.

At the Company's option, benefits may also be denied or suspended on any of the following dates:

(1) the date you (without good cause):
    (a) fail to take a required medical exam;
    (b) fail to cooperate with an examiner; or
    (c) postpone a required exam more than twice;
(2) the 45th day after the Company requests additional proof, if not given; or
(3) the 45th day after the Company requests proof of your application for any Other Income Benefits to which you may be entitled (and which affect Policy benefits); if not given.

Amount. The amount of the Weekly Total Disability Benefit equals:

(1) your Basic Weekly Earnings multiplied by the Benefit Percentage (limited to the Maximum Weekly Benefit); minus
(2) Other Income Benefits.

The amount of the Weekly Total Disability Benefit will not be less than the Minimum Weekly Benefit, unless the Minimum Weekly Benefit plus Other Income Benefits would exceed 100% of your Basic Weekly Earnings.

The Day Benefits Begin, Maximum Benefit Period, Benefit Percentage, Maximum Weekly Benefit, and Minimum Weekly Benefit are shown in the Schedule of Insurance.

PARTIAL DISABILITY BENEFIT. The Company will pay a Weekly Partial Disability Benefit, if you:

(1) become Partially Disabled while insured for this benefit;
(2) are engaged in Partial Disability Employment;
(3) are earning at least 20% of Basic Weekly Earnings when Partial Disability Employment begins;
(4) are under the Regular Care of a Physician; and
(5) at your own expense, submit proof of continued Partial Disability, Physician's care and reduced earnings to the Company upon request.

You are not required to be Totally Disabled prior to receiving Weekly Partial Disability Benefits. The Day Benefits Begin may be reached by days of Total Disability, Partial Disability, or any combination of these. Proportional benefits will be paid for a partial week of Partial Disability.

Duration. Benefits start on the Day Benefits Begin, and will cease on the earliest of:

(1) the date you cease to be Partially Disabled or die;
(2) the date the Maximum Benefit Period ends;
(3) the date you earn more than 99% of Basic Weekly Earnings; or
(4) the date you are able, but choose not to work Full-Time or part-time in your Own Occupation.

At the Company's option, benefits may also be denied or suspended on any of the following dates:

(1) the date you (without good cause):
  (a) fail to take a required medical exam;
  (b) fail to cooperate with an examiner; or
  (c) postpone a required exam more than twice;
(2) the 45th day after the Company requests additional proof, if not given; or
(3) the 45th day after the Company requests proof of your application for Other Income Benefits to which you may be entitled (and which affect Policy benefits); if not given.

Amount. The amount of the Weekly Partial Disability Benefit equals the lesser of A or B below:

(A) (1) Your Basic Weekly Earnings multiplied by the Benefit Percentage (limited to the Maximum Weekly Benefit); minus
  (2) Other Income Benefits, except for earnings you receive from Partial Disability Employment; or
(B) Your Basic Weekly Earnings minus Other Income Benefits.

The amount of the Weekly Partial Disability Benefit will not be less than the Minimum Weekly Benefit, unless the Minimum Weekly Benefit plus Other Income Benefits would exceed 100% of your Basic Weekly Earnings.

The Day Benefits Begin, Maximum Benefit Period, Benefit Percentage, Maximum Weekly Benefit, and Minimum Weekly Benefit are shown in the Schedule of Insurance.

OTHER INCOME BENEFITS means Earnings, benefits, awards, or settlements from the following sources. These amounts will be offset, in determining your Weekly Benefit. Except for Retirement Benefits and Earnings, these amounts must result from the same Disability for which a Weekly Benefit is payable under the Policy.

Compulsory Benefits. Any disability income benefits you are eligible to receive under:
(1) state temporary disability income benefit laws;
(2) state no fault auto insurance laws; or
(3) any other compulsory benefit act or law (except Workers' Compensation and laws of like intent).

Other Insurance Plans. Any disability income benefits for which you are eligible under any no fault auto plan.

Employer's Retirement Plan. Any Disability Benefits or Retirement Benefits you receive under the Employer's Retirement Plan.

Social Security and other Government Retirement Plans. The following Social Security or other Government Retirement Plan benefits will be offset:
(1) **disability benefits** for which you and any spouse or child is eligible, because of your Disability;
(2) **unreduced retirement benefits** for which you and any spouse or child is eligible, because of your eligibility for unreduced retirement benefits; or
(3) **reduced retirement benefits** actually received by you and any spouse or child, because of your receipt of reduced retirement benefits.

As used above, **"Government Retirement Plans"** include disability and retirement benefits under:
(1) the federal Social Security Act, Jones Act or Railroad Retirement Act;
(2) the Canada Pension Plan or Quebec Pension Plan;
(3) any similar plan or act of any country, state, province or other political unit; or
(4) any plan provided in place of one of the above plans.

"Earnings", as used in this provision, means pay you earn or receive from any occupation or form of employment, as reported for federal income tax purposes. Earnings include (but are not limited to) a:
(1) salaried or hourly Employee's gross earnings (shown on Form W-2); including:
  (a) wages, tips, commissions, bonuses and overtime pay; and
  (b) any pre-tax contributions to a Section 125 Plan, flexible spending account, or qualified deferred compensation plan;
(2) proprietor's net profit (figured from Form 1040, Schedule C);
(3) professional corporation shareholder's net profit (figured from Form 1040, Schedule C);
(4) partner's net earnings from self-employment (shown on Schedule K-1) and any W-2 earnings; and
(5) Subchapter S Corporation shareholder's net earnings from trade or business activities (shown on Schedule K-1).

Recovery from Third Party. Any amount you recover from a third party as a result of the Disability (whether by judgment, settlement or otherwise). The offset:

(1) will be reduced by attorney fees and other reasonable costs of recovery; and
(2) will not exceed 100% of the net settlement.

Exceptions. The following will **not** be considered Other Income Benefits, and will not be offset in determining the Weekly Benefit:

(1) a cost-of-living increase in any Other Income Benefit (except Earnings); if it takes effect after the first offset for that benefit during a period of Disability;
(2) reimbursement for hospital, medical or surgical expense;
(3) reimbursement for attorney fees or other reasonable costs of claiming Other Income Benefits;
(4) group credit or mortgage disability insurance;
(5) early retirement benefits that are not elected or received under the federal Social Security Act or other Government Retirement Plan;
(6) any amounts under the Employer's Retirement Plan that:
    (a) represent your contributions; or
    (b) are received upon termination of employment without being disabled or retired;
(7) benefits from a 401(k), profit-sharing or thrift plan; an individual retirement account (IRA); a tax sheltered annuity (TSA); a stock ownership plan; or a non-qualified plan of deferred compensation;
(8) vacation pay, holiday pay, or severance pay; or
(9) disability income benefits under any individual policy, association group plan, franchise plan, or auto liability insurance policy (except no fault auto insurance).

RULES CONCERNING OTHER INCOME BENEFITS. If you may be entitled to Other Income Benefits that affect Policy benefits, you are required to actively claim them. For example, if Social Security or other Government Retirement Plan benefits may be payable, you:

(1) must promptly apply for such benefits; and, if denied
(2) must file an appeal or request an administrative hearing, upon Company request.

If you fail to promptly pursue such benefits, the Company has the option to deny or suspend Weekly Benefits or to reduce them by an estimated amount.

If Workers' Compensation or similar benefits may be payable for the same Disability, you and your Employer are required to cooperate in filing for those benefits. The Company will require proof of the denial or duration of those benefits to confirm its liability under the Policy.

Refunding Overpayments. Upon receiving Other Income Benefits, you must refund any resulting overpayment of Weekly Benefits under the Policy. If you do not promptly refund an overpayment to the Company within 60 days, in a lump sum, then:

(1) the Company will reduce or eliminate future payments; and
(2) the Minimum Weekly Benefit will not apply, until the amount is repaid.

Cost of Living Freeze. After the first deduction for each of the Other Income Benefits (except Earnings), its amount will be frozen. The Weekly Benefit will not be further reduced due to any cost-of-living increases payable under these Other Income Benefits.

RECURRENT DISABILITY. "Recurrent Disability" means a Disability caused by an Injury or Sickness which is the same as, or related to, the cause of a prior Disability for which Weekly Benefits were payable.

(1) A Recurrent Disability will be treated as a new period of Disability, if you:
   (a) have returned to your Own Occupation; and
   (b) have worked on a full-time basis, for two consecutive weeks or more.
   A new Day Benefits Begin and new Maximum Benefit Period will apply.

(2) A Recurrent Disability will be treated as part of the prior Disability, if you:
   (a) have returned to your Own Occupation; and
   (b) have worked on a full-time basis, for less than two consecutive weeks.
   The same Day Benefits Begin and same Maximum Benefit Period will apply to the Recurrent Disability as to the prior Disability.

To qualify for a Weekly Benefit for a Recurrent Disability, you must earn less than the percentage of Predisability Income specified in the Partial Disability Benefit section. Benefit payments will be subject to all other terms of the Policy that applied to the prior Disability.

This Recurrent Disability provision will cease to apply when you become eligible for coverage under any other group short-term disability policy.

EXCLUSIONS. Weekly Benefits will not be payable for any period of Disability:

(1) which is the result of an intentionally self-inflicted Injury or suicide attempt;
(2) during which you are not under the Regular Care of a Physician;
(3) which is the result of war (declared or undeclared) or any act of war;
(4) which is the result of a Sickness or Injury for which you receive benefits under Workers' Compensation or similar coverage;
(5) which arises out of (or in the course of) any employment for wage or profit, when the Disability would be covered by Workers' Compensation or similar coverage if:
   (a) the Employer had enrolled you for such coverage; and
   (b) you and your Employer had cooperated in filing a claim under that plan; or
(6) during which you receive payment under the Employer's Sick Leave or Salary Continuance Plan.

PRE-EXISTING CONDITION LIMITATION. The Policy will not cover any period of Disability:

(1) which is caused or contributed to by, or results from a Pre-Existing Condition; and
(2) which begins in the first 12 months after your Effective Date, unless you received no Treatment of the condition for 12 months in a row after your Effective Date.

"Pre-Existing Condition" means a Sickness or Injury for which you received Treatment within 3 months prior to your Effective Date.

"Treatment" means consultation, care and services by a Physician. It includes diagnostic measures and the prescription, refill and taking of prescribed drugs or medicines.

GENERAL PURPOSES AND LIMITATIONS OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION K.S.A.40-3001 et. seq.

DISCLAIMER

THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MAY NOT PROVIDE COVERAGE FOR ALL OR A PORTION OF THIS POLICY. IF COVERAGE IS PROVIDED, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS AND EXCLUSIONS, AND IS CONDITIONED UPON RESIDENCY IN THIS STATE. THEREFORE, YOU SHOULD NOT RELY UPON COVERAGE BY THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELECTING AN INSURANCE COMPANY OR IN SELECTING AN INSURANCE POLICY. INSURANCE COMPANIES AND THEIR AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELLING YOU ANY FORM OF AN INSURANCE POLICY, OR TO INDUCE YOU TO PURCHASE ANY FORM OF AN INSURANCE POLICY. EITHER THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE KANSAS INSURANCE DEPARTMENT WILL RESPOND TO ANY QUESTIONS YOU HAVE REGARDING THIS DOCUMENT.

Kansas Life and Health Insurance
Guaranty Association
2909 SW Maupin Lane
Topeka, KS 66614

Kansas Insurance Department
420 SW 9th Street
Topeka, KS 66612

This is a brief summary of the Kansas Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. If there is any inconsistency between this notice and Kansas law, then Kansas law will control.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Kansas law, with funding from assessments paid by other insurance companies. This safety net was created under Kansas law, which determines who and what is covered and the amounts of coverage. The basic protections provided by the Association are:

- Life Insurance

  $300,000 in death benefits

  $100,000 in cash surrender or withdrawal values

- Health Insurance

  $500,000 in hospital, medical and surgical insurance benefits

  $300,000 in disability insurance benefits

  $300,000 in long-term care insurance benefits

  $100,000 in other types of health insurance benefits

- Annuities

  $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits, as well as certain aggregate limits.

CERTIFICATE AMENDMENT

TO BE ATTACHED TO THE CERTIFICATE FOR GROUP POLICY NO.: 000010147074

ISSUED TO: USD 262 Valley Center Schools

Your Certificate is amended by adding the following provisions.

PRIOR INSURANCE CREDIT UPON TRANSFER OF
DISABILITY INCOME INSURANCE CARRIERS

This provision prevents loss of disability income coverage for you, which could otherwise occur solely because of a transfer of insurance carriers. The Policy will provide the following Prior Insurance Credit, when it replaces a prior plan.

"Prior Plan" means a prior carrier's group disability income policy, which the Policy replaced within 1 day of the prior plan's termination date.

FAILURE TO SATISFY ACTIVE WORK RULE. Subject to premium payments, the Policy will provide disability income coverage if you:

(1) were insured by the prior plan on its termination date; and
(2) were otherwise eligible under the Policy; but were not Actively-At-Work due to Injury or Sickness on its Effective Date.

AMOUNT OF COVERAGE. Until you satisfy the Policy's Active Work rule, your disability income coverage will not exceed that provided by the prior plan, had it remained in force. The Company will pay:

(1) the benefit the prior plan would have paid; minus
(2) any amount for which the prior carrier is liable.

DISABILITY DUE TO A PRE-EXISTING CONDITION. Benefits may be payable for a period of disability due to a Pre-Existing Condition if you:

(1) were insured by the prior plan on its termination date; and
(2) were Actively-At-Work and became insured under the Policy on its Effective Date.

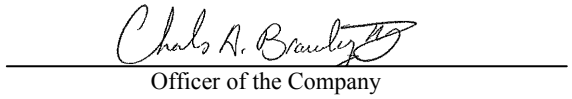
The benefits will be determined as follows:

A. The Company will apply the Policy's Pre-Existing Condition Limitation. If you qualify for benefits, you will be paid according to the Policy's benefit schedule.

B. If you cannot satisfy the Policy's Pre-Existing Condition Limitation; then the prior plan's pre-existing condition limitation will be applied, as follows:
   (1) If you satisfy the prior plan's pre-existing condition limitation, giving consideration towards continuous time insured under both policies; then benefits will be paid according to the prior plan's benefit schedule.
   (2) If you cannot satisfy the Pre-Existing Condition Limitation of the Policy, or that of the prior plan; then no benefit will be paid.

This Amendment takes effect on your effective date of coverage under the Policy. In all other respects, your Certificate remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

Lincoln Financial Group®

LINCOLN FINANCIAL GROUP® PRIVACY PRACTICES NOTICE

The Lincoln Financial Group companies* are committed to protecting your privacy. To provide the products and services you expect from a financial services leader, we must collect personal information about you. **We do not sell your personal information to third parties.** We share your personal information with third parties as necessary to provide you with the products or services you request and to administer your business with us. This Notice describes our current privacy practices. While your relationship with us continues, we will update and send our Privacy Practices Notice as required by law. Even after that relationship ends, we will continue to protect your personal information. **You do not need to take any action because of this Notice, but you do have certain rights as described below.**

INFORMATION WE MAY COLLECT AND USE

We collect personal information about you to help us identify you as our customer or our former customer; to process your requests and transactions; to offer investment or insurance services to you; to pay your claim; or to tell you about our products or services we believe you may want and use. The type of personal information we collect depends on the products or services you request and may include the following:

- **Information from you**: When you submit your application or other forms, you give us information such as your name, address, Social Security number; and your financial, health, and employment history.

- **Information about your transactions**: We keep information about your transactions with us, such as the products you buy from us; the amount you paid for those products; your account balances; and your payment history.

- **Information from outside our family of companies**: If you are purchasing insurance products, we may collect information from consumer reporting agencies such as your credit history; credit scores; and driving and employment records. With your authorization, we may also collect information, such as medical information from other individuals or businesses.

- **Information from your employer**: If your employer purchases group products from us, we may obtain information about you from your employer in order to enroll you in the plan.

HOW WE USE YOUR PERSONAL INFORMATION

We may share your personal information within our companies and with certain service providers. They use this information to process transactions you have requested; provide customer service; and inform you of products or services we offer that you may find useful. Our service providers may or may not be affiliated with us. They include financial service providers (for example, third party administrators; broker-dealers; insurance agents and brokers, registered representatives; reinsurers and other financial services companies with whom we have joint marketing agreements). Our service providers also include non-financial companies and individuals (for example, consultants; vendors; and companies that perform marketing services on our behalf). Information we obtain from a report prepared by a service provider may be kept by the service provider and shared with other persons; however, we require our service providers to protect your personal information and to use or disclose it only for the work they are performing for us, or as permitted by law.

When you apply for one of our products, we may share information about your application with credit bureaus. We also may provide information to group policy owners, regulatory authorities and law enforcement officials and to others when we believe in good faith that the law requires disclosure. In the event of a sale of all or part of our businesses, we may share customer information as part of the sale. **We do not sell or share your information with outside marketers who may want to offer you their own products and services; nor do we share information we receive about you from a consumer reporting agency. You do not need to take any action for this benefit.**

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

SECURITY OF INFORMATION

We have an important responsibility to keep your information safe. We use safeguards to protect your information from unauthorized disclosure. Our employees are authorized to access your information only when they need it to provide you with products, services, or to maintain your accounts. Employees who have access to your personal information are required to keep it confidential. Employees are trained on the importance of data privacy.

Questions about your personal information should be directed to:

Lincoln Financial Group
Attn: Enterprise Compliance and Ethics
Corporate Privacy Office, 7C-01
1300 S. Clinton St.
Fort Wayne, IN 46802

Please include all policy/contract/account numbers with your correspondence.

*This information applies to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company
Lincoln Financial Group Trust Company, LLC
Lincoln Financial Investment Services Corporation
Lincoln Investment Advisors Corporation
Lincoln Life & Annuity Company of New York
Lincoln Retirement Services Company, LLC
Lincoln Variable Insurance Products Trust
The Lincoln National Life Insurance Company

ADDITIONAL PRIVACY INFORMATION FOR INSURANCE PRODUCT CUSTOMERS

CONFIDENTIALITY OF MEDICAL INFORMATION

We understand that you may be especially concerned about the privacy of your medical information. We do not sell or rent your medical information to anyone; nor do we share it with others for marketing purposes. We only use and share your medical information for the purpose of underwriting insurance, administering your policy or claim and other purposes permitted by law, such as disclosure to regulatory authorities or in response to a legal proceeding.

MAKING SURE MEDICAL INFORMATION IS ACCURATE

We want to make sure we have accurate information about you. Upon written request we will tell you, within 30 business days, what personal information we have about you. You may see a copy of your personal information in person or receive a copy by mail, whichever you prefer. We will share with you who provided the information. In some cases we may provide your medical information to your personal physician. We will not provide you with information we have collected in connection with, or in anticipation of, a claim or legal proceeding. If you believe that any of our records are not correct, you may write and tell us of any changes you believe should be made. We will respond to your request within 30 business days. A copy of your request will be kept on file with your personal information so anyone reviewing your information in the future will be aware of your request. If we make changes to your records as a result of your request, we will notify you in writing and we will send the updated information, at your request, to any person who may have received the information within the prior two years. We will also send the updated information to any insurance support organization that gave us the information, and any service provider that received the information within the prior 7 years.

Questions about your personal medical information should be directed to:

Lincoln Financial Group
Attn: Medical Underwriting
P.O. Box 21008
Greensboro, NC 27420-1008

The CONFIDENTIALITY OF MEDICAL INFORMATION and MAKING SURE INFORMATION IS ACCURATE sections of this Notice apply to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company
Lincoln Life & Annuity Company of New York
The Lincoln National Life Insurance Company

The Lincoln National Life Insurance Company

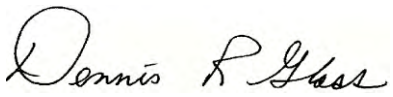
A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066 (402) 361-7300

CERTIFIES THAT Group Policy No. GL 000010147074 has been issued to
USD 262 Valley Center Schools
(The Group Policyholder)

The Issue Date of the Policy is October 1, 2011.

Certificate of Insurance for Class 3

You are entitled to the benefits described in this Certificate only if you are eligible, become and remain insured under the provisions of the Policy. This Certificate replaces any other certificates for the benefits described inside. As a Certificate of Insurance, it is not a contract of insurance; it only summarizes the provisions of the Policy and is subject to the Policy's terms. If the provisions of this Certificate and the Policy do not agree, the provisions of the Policy will apply.



President

CERTIFICATE OF GROUP INSURANCE
PROVIDING
WEEKLY DISABILITY INCOME INSURANCE

USD 262 Valley Center Schools
000010147074

SCHEDULE OF INSURANCE

CLASS 3

All Full-Time Employees Electing a 61/61/26 benefit

WAITING PERIOD: None (For date insurance begins, refer to "Effective Dates" section)

MINIMUM HOURS: 20 hours per week

WEEKLY DISABILITY INCOME INSURANCE

BENEFIT PERCENTAGE: 66 2/3%

MAXIMUM WEEKLY BENEFIT: $1,730

MINIMUM WEEKLY BENEFIT: 10% of your Weekly Total Disability Benefit

MAXIMUM BENEFIT PERIOD: 26 weeks

DAY BENEFITS BEGIN: 61st consecutive day of Disability due to accidental Injury; and
61st consecutive day of Disability due to Sickness.

The Day Benefits Begin may be reached by days of Total Disability, Partial Disability, or any combination thereof.

The Maximum Weekly Benefit will not exceed the Benefit Percentage times Basic Weekly Earnings.

After the Day Benefits Begin, the Maximum Benefit Period will be reduced by any days for which you receive payment under the Employer's Sick Leave or Salary Continuance Plan for the same Disability.

Weekly Disability Income Insurance will terminate when you retire.

The Policy does not replace or provide benefits required by Workers' Compensation laws or any state disability insurance plan laws.

CONTRIBUTIONS: You are required to contribute to the cost of the Weekly Disability Income Insurance.

TABLE OF CONTENTS

DEFINITIONS

As used throughout the Policy, the following terms shall have the meanings indicated below. Other parts of the Policy contain definitions specific to those provisions.

ACTIVE WORK or ACTIVELY AT WORK means your performance of all Main Duties of your Own Occupation, for the regularly scheduled number of hours, at:

(1) the Employer's place of business; or
(2) any other business location where the Employer requires you to travel.

Unless disabled on the prior workday or on the day of absence, you will be considered Actively at Work on the following days:

(1) a Saturday, Sunday or holiday that is not a scheduled workday;
(2) a paid vacation day, or other scheduled or unscheduled non-workday; or
(3) a non-medical leave of absence of 12 weeks or less, whether taken with the Employer's prior approval or on an emergency basis.

This includes a Military Leave or an approved Family or Medical Leave that is not due to your own health condition.

BASIC WEEKLY EARNINGS or **PREDISABILITY INCOME** means your average weekly base salary or hourly pay from the Employer before taxes on the Determination Date. The **"Determination Date"** is the last day worked just prior to the date the Disability begins.

It does **not** include commissions, bonuses, overtime pay, or any other extra compensation. It does **not** include income from a source other than the Employer. It will not exceed the amount shown in the Employer's financial records, the amount for which premium has been paid, or the Maximum Covered Weekly Earnings permitted by the Policy; whichever is less. (Maximum Covered Weekly Earnings equals the Maximum Weekly Benefit divided by the Benefit Percentage shown in the Schedule of Insurance.) Exception: For purposes of determining the Partial Disability Weekly Benefit, Basic Weekly Earnings will not exceed the amount shown in the Employer's financial records.

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

DAY or **DATE** means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, standard time, at the Group Policyholder's place of business. When used with regard to effective dates, it means 12:01 a.m. When used with regard to termination dates, it means 12:00 midnight.

DISABILITY or DISABLED means Total Disability or Partial Disability.

DISABILITY BENEFIT, when used with the term Retirement Plan, means a benefit that:
(1) is payable under a Retirement Plan due to disability as defined in that plan; and
(2) does not reduce the benefits that would have been paid as Retirement Benefits at the normal retirement age under the plan if the disability had not occurred.

If the payment of the benefit does cause such a reduction, the benefit will be deemed a Retirement Benefit as defined in the Policy.

EMPLOYEE or FULL-TIME EMPLOYEE means a person:
(1) whose employment with the Employer is the person's main occupation;
(2) whose employment is for regular wage or salary;
(3) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Insurance per week;
(4) who is a member of an Eligible Class which is eligible for coverage under the Policy;
(5) who is not a temporary or seasonal employee; and
(6) who is a citizen of the United States or legally works in the United States.

EMPLOYER means the Group Policyholder. It includes any division, subsidiary or affiliated company named in the Application or Participation Agreement.

EVIDENCE OF INSURABILITY means a statement of proof of your medical history. The Company uses this to determine your acceptance for insurance or an increased amount of insurance. Such proof will be provided at your own expense.

FAMILY OR MEDICAL LEAVE means an approved leave of absence that:
(1) is subject to the federal FMLA law (the Family and Medical Leave Act of 1993 and any amendments to it) or a similar state law;
(2) is taken in accord with the Employer's leave policy and the law which applies; and
(3) does not exceed the period approved by the Employer and required by that law.

Under the federal FMLA law, such leaves are permitted for up to 12 weeks in a 12-month period as defined by the Employer. The 12 weeks:
(1) may consist of consecutive or intermittent work days; or
(2) may be granted on a part-time equivalency basis.

If you are entitled to a leave under both the federal FMLA law and a similar state law, you may elect the more favorable leave (but not both). If you are on an FMLA leave due to your own health condition on the date Policy coverage takes effect, you are not considered Actively at Work.

FULL-TIME, as it applies to the Partial Disability Benefit, means the average number of hours you were regularly scheduled to work, at your Own Occupation, during the week just prior to:
(1) the date Disability begins; or
(2) the date an approved leave of absence begins, if Disability begins while you are continuing coverage during a leave of absence.

GROUP POLICYHOLDER means the person, company, trust or other organization as shown on the Title Page of the Policy.

INJURY means bodily Injury which results directly from an accident, independently of all other causes. In determining Weekly Benefits, a Disability will be considered caused by a Sickness if:
(1) the Disability begins more than 60 days after the Injury; or
(2) the Injury occurred before your Effective Date under the Policy.

The term "Injury" shall not include any:
(1) condition to which a Sickness, its natural progression or its treatment is a substantial contributing cause (based upon the preponderance of medical evidence);
(2) condition caused by emotional stress or trauma; infection (except pyogenic bacterial infection of an Injury); or medical or surgical treatment (except when needed solely for an Injury);
(3) repetitive trauma condition which results from repetitious, physically traumatic activities that occur over time; or
(4) pregnancy; except for complications that result from an Injury.

INSURANCE MONTH or **POLICY MONTH** means that period of time:
(1) beginning at 12:01 a.m. Standard Time, at the Group Policyholder's place of business on the first day of any calendar month; and
(2) ending at 12:00 midnight on the last day of the same calendar month.

INSURED PERSON means a Person for whom Policy coverage is in effect.

MAIN DUTIES or **MATERIAL AND SUBSTANTIAL DUTIES** means those job tasks that:
(1) are normally required to perform your Own Occupation; and
(2) could not reasonably be modified or omitted.

To determine whether a job task could reasonably be modified or omitted, the Company will apply the Americans with Disabilities Act's standards concerning reasonable accommodation. It will apply the Act's standards, whether or not:
(1) the Employer is subject to the Act; or
(2) you have requested such a job accommodation.
An Employer's failure to modify or omit other job tasks does **not** render you unable to perform the Main Duties of the job.

Main Duties include those job tasks:
(1) as described in the U.S. Department of Labor Dictionary of Occupational Titles; and
(2) as performed in the general labor market and national economy.
Main Duties are **not** limited to those specific job tasks as performed for a certain firm or at a certain work site.

MEDICALLY APPROPRIATE TREATMENT means diagnostic services, consultation, care or services that are consistent with the symptoms or diagnosis causing your Disability. Such treatment must be rendered:
(1) by a Physician whose license and any specialty are consistent with the disabling condition; and
(2) according to generally accepted, professionally recognized standards of medical practice.

MILITARY LEAVE means a leave of absence that:
(1) is subject to the federal USERRA law (the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it);
(2) is taken in accord with the Employer's leave policy and the federal USERRA law; and
(3) does not exceed the period required by that law.

OWN OCCUPATION or **REGULAR OCCUPATION** means the occupation, trade or profession:
(1) in which you were employed with the Employer prior to Disability; and
(2) which was your main source of earned income prior to Disability.

It means a collective description of related jobs, as defined by the U.S. Department of Labor Dictionary of Occupational Titles. It includes any work in the same occupation for pay or profit, regardless of:
(1) whether such work is with the Employer, with some other firm, or on a self-employed basis; or
(2) whether a suitable opening is currently available with the Employer or in the local labor market.

PARTIAL DISABILITY or **PARTIALLY DISABLED** means that, due to an Injury or Sickness, you:
(1) are unable to perform one or more of the Main Duties of your Own Occupation, or are unable to perform such duties Full-Time; and
(2) are engaged in Partial Disability Employment.

PARTIAL DISABILITY EMPLOYMENT means you are working at your Own Occupation or any other occupation; however, because of a Partial Disability:
(1) your hours or production is reduced;
(2) one or more Main Duties of the job are reassigned; or
(3) you are working in a lower-paid occupation.

During Partial Disability Employment, your current earnings:
(1) must be at least 20% of Predisability Income; and
(2) may not exceed the percentage specified in the Partial Disability Benefit section.

PERSON means an Employee of the Employer:
(1) who is a member of an Employee class which is eligible for coverage under the Policy; and
(2) who has completed an enrollment form.

PERSONAL INSURANCE means the insurance provided by the Policy on Insured Persons.

PHYSICIAN means:
(1) a legally qualified medical doctor who is licensed to practice medicine, to prescribe and administer drugs, or to perform surgery; or
(2) any other duly licensed medical practitioner who is deemed by state law to be the same as a legally qualified medical doctor.

The medical doctor or other medical practitioner must be acting within the scope of his or her license. He or she must be qualified to provide Medically Appropriate Treatment for your disabling condition.

Physician does **not** include you or your relatives. Relatives include:
(1) your spouse, siblings, parents, children and grandparents; and
(2) your spouse's relatives of like degree.

POLICY means the group insurance Policy issued by the Company to the Group Policyholder.

PREDISABILITY INCOME--See Basic Weekly Earnings definition.

REGULAR CARE OF A PHYSICIAN means you:
(1) personally visit a Physician, as often as medically required according to standard medical practice to effectively manage and treat your disabling condition; and
(2) receive Medically Appropriate Treatment, by a Physician whose license and any specialty are consistent with the disabling condition.

REGULAR OCCUPATION--See Own Occupation or Regular Occupation definition.

RETIREMENT BENEFIT, when used with the term Retirement Plan, means a benefit that:
(1) is payable under a Retirement Plan either in a lump sum or in the form of periodic payments;
(2) does not represent contributions made by you (Payments representing Employee contributions are deemed to be received over your expected remaining life, regardless of when they are actually received.); and
(3) is payable upon:
    (a) early or normal retirement; or
    (b) disability (if the payment does reduce the benefit which would have been paid at the normal retirement age under the plan, if disability had not occurred).

RETIREMENT PLAN means a defined benefit or defined contribution plan that:
(1) provides Retirement Benefits to Employees; and
(2) is not funded wholly by Employee contributions.

The term shall not include any 401(k), profit-sharing or thrift plan; informal salary continuance plan; individual retirement account (IRA); tax sheltered annuity (TSA); stock ownership plan; or a non-qualified plan of deferred compensation.

An Employer's Retirement Plan is deemed to include any Retirement Plan:
(1) which is part of any federal, state, county, municipal or association retirement system; and
(2) for which you are eligible as a result of employment with the Employer.

SICK LEAVE or **SALARY CONTINUANCE PLAN** means a plan that:

(1) is established and maintained by the Employer for the benefit of Employees; and
(2) continues payment of all or part of your Predisability Income for a specified period after you become Disabled.

It does **not** include compensation the Employer pays you for work actually performed during a Disability.

SICKNESS means illness, pregnancy or disease.

TOTAL DISABILITY or **TOTALLY DISABLED** means your inability, due to Sickness or Injury, to perform each of the Main Duties of your Own Occupation. A Person engaging in any employment for wage or profit is not Totally Disabled. The loss of a professional license, an occupational license or certification, or a driver's license for any reason does **not**, by itself, constitute Total Disability.

WAITING PERIOD means the period of time you must be employed in an eligible class with the Employer, before you become eligible to enroll for coverage under the Policy. The period of service must be continuous, except as explained in the Eligibility provision captioned Prior Service Credit Towards Waiting Period.

WEEKLY BENEFIT means the amount payable weekly by the Company to you while you are Totally Disabled or Partially Disabled.

WORKERS' COMPENSATION OR SIMILAR COVERAGE means coverage under a law that compensates for job related Injury or Sickness. It includes (but is not limited to):

(1) coverage under any Workers' Compensation or occupational disease law;
(2) coverage under the Jones Act; the Longshoreman's and Harbor Worker's Act; the Maritime Doctrine of Maintenance, Wages or Cure; or
(3) any plan provided in place of one of those plans.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties shall consist of:
(1) the Policy and any amendments to it;
(2) the Group Policyholder's application (a copy of which is attached to the Policy);
(3) any Participating Employers' applications or Participation Agreements; and
(4) any individual applications of Insured Persons.

In the absence of fraud, all statements made by the Group Policyholder and by Insured Persons are representations and not warranties. No statement made by an Insured Person will be used to contest the coverage provided by the Policy, unless:
(1) it is contained in a written statement signed by that Insured Person; and
(2) a copy of the statement has been furnished to that Insured Person.

Only an Officer of the Company may change this Policy or extend the time for payment of any premium. No change will be valid unless made in writing and signed by an Officer of the Company. Any change so made will be binding on all persons referred to in the Policy.

INCONTESTABILITY. Except for the non-payment of premiums or fraud, the Company may not contest the validity of the Policy after it has been in force for two years from its date of issue; and as to any Insured Person, after his or her coverage has been in force for two years during his or her lifetime. This clause does not preclude, at any time, the assertion of defenses based upon:
(1) the Policy's eligibility requirements, exclusions and limitations; and
(2) other Policy provisions unrelated to the validity of coverage.

RESCISSION. The Company has the right to rescind any insurance for which Evidence of Insurability was required, if:
(1) you incur a claim during the first two years of coverage; and
(2) the Company discovers that you made a Material Misrepresentation on your application.

A **"Material Misrepresentation"** is an incomplete or untrue statement that caused the Company to issue coverage that it would have disapproved, had it known the truth. No misrepresentation is material unless the statement misrepresented actually contributes to the contingency or event on which the coverage is to become due and payable. **"To rescind"** means to cancel insurance back to its effective date. In that event, the Company will refund all premium paid for the rescinded insurance, less any benefits paid for your claims. The Company reserves the right to recover any claims paid in excess of such premiums.

MISSTATEMENTS OF FACTS. If relevant facts about any Person were misstated:
(1) a fair adjustment of the premium will be made; and
(2) the true facts will decide if and in what amount insurance is valid under the Policy.
If your age has been misstated, any benefits shall be in the amount the paid premium would have purchased at the correct age.

GROUP POLICYHOLDER'S AGENCY. For all purposes of the Policy, the Group Policyholder acts on its own behalf or as an agent of the Insured Person. Under no circumstances will the Group Policyholder be deemed the agent of the Company.

CURRENCY. In administering the Policy:
(1) all Predisability Income will be expressed in U.S. dollars; and
(2) all premium and benefits must be paid in U.S. dollars.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE. The Policy does not replace or provide benefits required by:
(1) Workers' Compensation laws; or
(2) any state temporary disability insurance plan laws.

ASSIGNMENT. The rights and benefits under this Certificate may not be assigned.

ELIGIBILITY AND EFFECTIVE DATES

ELIGIBLE CLASSES. The classes of Employees eligible for insurance are shown in the Schedule of Insurance. The Company has the right to review and terminate any or all classes eligible under the Policy, if any class ceases to be covered by the Policy.

ELIGIBILITY. A Person becomes eligible for coverage provided by the Policy on the later of:
(1) the Policy's date of issue; or
(2) the date the Waiting Period is completed.

Prior Service Credit Towards Waiting Period. The Waiting Period is shown in the Schedule of Insurance. Prior service in an Eligible Class will apply toward the Waiting Period, when:
(1) you are a former Employee and are rehired within one year after your employment ends;
(2) you return from an approved Family or Medical Leave within:
  (a) the 12-week period required by federal law; or
  (b) any longer period required by a similar state law; or
(3) you return from a Military Leave within the period required by federal USERRA law.

EFFECTIVE DATE. Your initial amount of Personal Insurance becomes effective at 12:01 a.m. on the latest of:
(1) the first day of the Insurance Month following the date you become eligible for the coverage;
(2) the date you resume Active Work, if not Actively at Work on the day you become eligible;
(3) the date you make written application for coverage and sign:
  (a) a payroll deduction order, if you pay any part of the Policy premiums; or
  (b) an order to pay premiums from your Flexible Benefits Plan account, if Employer contributions are made through such an account; or
(4) the date the Company approves your Evidence of Insurability, if required.

Any increased or additional coverage becomes effective at 12:01 a.m. on the latest of:
(1) the first day of the Insurance Month coinciding with or next following the day on which you become eligible for the increase, if Actively at Work on that day;
(2) the date you resume Active Work, if not Actively at Work on the day the increase would otherwise take effect; or
(3) the date any required Evidence of Insurability is approved by the Company.

Any decrease will take effect on the day of the change, whether or not you are Actively at Work.

Evidence of Insurability. Evidence of Insurability satisfactory to the Company must be submitted (at your expense) when:
(1) you make written application for coverage (or an increased amount of coverage) more than 31 days after becoming eligible for the coverage; or
(2) you make written application for coverage after you have requested:
  (a) to cancel insurance;
  (b) to stop payroll deductions for the insurance; or
  (c) to stop premium payments from the Flexible Benefits Plan account.

Effective Date for Change in Eligible Class. You may become a member of a different Eligible Class. Coverage under the different Eligible Class will be effective:
(1) on the first day of the Insurance Month coinciding with or next following the date of the change;
(2) except as stated in the Effective Date provision for increases or decreases.

ELIGIBILITY AND EFFECTIVE DATES
(Continued)

REINSTATEMENT RIGHTS. If your coverage terminates due to one of the following breaks in service, you will be entitled to reinstate the coverage upon resuming Active Work with the Employer within the required timeframe. **"Reinstatement"** or **"to reinstate"** means to re-enroll for Policy coverage, without satisfying a new Waiting Period or providing Evidence of Insurability. Reinstatement is available upon:

(1) return from an approved Family or Medical Leave within:
  (a) the 12-week period required by federal law; or
  (b) any longer period required by a similar state law;
(2) return from a Military Leave within the period required by federal USERRA law;
(3) return from any other approved leave of absence within six months after the leave begins;
(4) return within 12 months following a lay off; or
(5) return within 12 months following termination of employment for any other reason.

To reinstate coverage, you must apply for coverage or be re-enrolled within 31 days after resuming Active Work in an Eligible Class. The reinstated amount of insurance may not exceed the amount that terminated. Reinstatement will take effect on the date you return to Active Work.

If the above conditions are met, and the Policy includes a Pre-Existing Condition Exclusion, then:

(1) the months of leave will count towards any unmet Pre-Existing Condition Exclusion period; and
(2) a new Pre-Existing Condition Exclusion will not apply to the reinstated amount of insurance.

A new Pre-Existing Condition Exclusion will apply to any increased amount of insurance.

INDIVIDUAL TERMINATIONS

TERMINATION OF COVERAGE. Your coverage will terminate at 12:00 midnight on the earliest of:

(1) the date the Policy terminates or the Employer's participation ends (but without prejudice to any claim incurred prior to termination);
(2) the date your class is no longer eligible for insurance;
(3) the date you cease to be a member of an Eligible Class;
(4) the last day of the Insurance Month in which you request termination;
(5) the last day of the last Insurance Month for which premium payment is made on your behalf;
(6) the end of the period for which the last required premium has been paid;
(7) with respect to any particular insurance benefit, the day the portion of the Policy providing that benefit terminates;
(8) the date your employment with the Group Policyholder or Participating Employer terminates (unless coverage is continued as provided below); or
(9) the date you enter the armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard. (If you send proof of military service, the Company will refund any unearned premium.)

CONTINUATION RIGHTS. Ceasing Active Work results in termination of your eligibility for coverage, but coverage may be continued as follows.

Disability. If you are absent due to Total Disability or engaged in Partial Disability Employment, coverage may be continued:

(1) until the Day Benefits Begin; and
(2) during the period for which benefits are payable.

The Company must receive the required premium from the Employer.

INDIVIDUAL TERMINATIONS
(Continued)

Family or Medical Leave. If you go on an approved Family or Medical Leave and are **not** entitled to the more favorable continuation available during Disability, coverage may be continued until the earliest of:

(1) the end of the leave period approved by the Employer;
(2) the end of the 12-week leave period required by federal law, or any more favorable period required by a similar state law;
(3) the date you notify the Employer that you will not return; or
(4) the date you begin employment with another employer.

The required premium payments must be received from the Employer, throughout the period of continued coverage.

Military Leave. If you go on a Military Leave, coverage may be continued for the same period allowed for an approved Family or Medical Leave. The required premium payments must be received from the Employer, throughout the period of continued coverage.

Lay Off or Other Leave. If you cease work due to a temporary lay off, or due to an approved leave of absence (other than an approved Family or Medical Leave or a Military Leave); coverage may be continued for three Insurance Months after the lay off or leave begins. The required premium payments must be received from the Employer, throughout the period of continued coverage.

Conditions. In administering the above continuations, the Employer must not act so as to discriminate unfairly among Insured Persons in similar situations. Insurance may **not** be continued when you cease Active Work due to a labor dispute, strike, work slowdown or lockout.

INDIVIDUAL TERMINATION DURING DISABILITY. Termination of your coverage during a Disability will have no effect on benefits payable for that period of Disability.

CLAIMS PROCEDURES
FOR WEEKLY DISABILITY INCOME BENEFITS

NOTICE AND PROOF OF CLAIM -- Notice of Claim. Written notice of a Disability claim must be given:
(1) within 20 days after the Injury or Sickness causing Disability begins; or
(2) as soon as reasonably possible after that.*
The notice must be sent to the Company's Group Insurance Service Office. It should include your name and address, and the number of the Policy.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days, you may send the Company written proof of Disability in a letter. It should state the date the Disability began, its cause and degree. The Company will periodically send you additional claim forms.

Proof of Claim. The Company must be given written proof of a Disability claim:
(1) within 90 days after the Day Benefits Begin; or
(2) as soon as reasonably possible after that.*

Proof of claim must be provided at your own expense. It must show the date the Disability began, its cause and degree. Documentation must include the following:
(1) completed statements by you and your Employer;
(2) a completed statement by the attending Physician, which must describe any restrictions on the performance of the duties of your Regular Occupation;
(3) proof of any other income received, and of any other benefits available from other income sources, which may affect Policy benefits;
(4) a signed authorization for the Company to obtain more information; and
(5) any other items the Company may reasonably require in support of the claim.

Proof of continued Disability, Regular Care of a Physician, and any Other Income Benefits affecting the claim must be given to the Company. This must be supplied within 45 days after the Company requests it. If it is not, benefits may be denied or suspended.

***Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim, if it is shown that it was done:
(1) as soon as reasonably possible; and
(2) in no event more than one year after it was required.
These time limits will not apply while you lack legal capacity.

EXAMINATION. The Company may have you examined:
(1) by a Physician, specialist or vocational rehabilitation expert of the Company's choice;
(2) as often as reasonably required while a claim or appeal is pending.

Any such exam will be at the Company's expense.

The Company may determine that (in its opinion) you have:
(1) failed to cooperate with an examiner;
(2) failed to take an exam scheduled by the Company; or
(3) postponed such an exam more than twice.
In that event, benefits may be denied or suspended, until the required exam is completed.

CLAIMS PROCEDURES
(Continued)

TIME OF PAYMENT OF CLAIMS. Weekly Disability Income Benefits payable under the Policy will be paid immediately after the Company receives complete proof of claim and confirms liability. Such benefits will be paid biweekly, during any period for which the Company is liable. If benefits are due for less than a week, they will be paid on a pro rata basis. The daily rate will equal 1/7 of the Weekly Benefit. Any balance, which remains unpaid at the end of the period of liability, will be paid immediately after the Company receives complete proof of claim and confirms liability.

TO WHOM PAYABLE. All Weekly Disability Income Benefits are payable to you, while living. After your death, such benefits will be payable to your estate.

NOTICE OF CLAIM DECISION. The Company will send you a written notice of its claim decision. If the Company denies any part of the claim, the written notice will explain:

(1) the reason for the denial, under the terms of the Policy and any internal guidelines;
(2) how you may request a review of the Company's decision; and
(3) whether more information is needed to support the claim.

This notice will be sent within 15 days after the Company resolves the claim. It will be sent within 45 days after the Company receives the first proof of claim, if reasonably possible.

Delay Notice. The Company may need more than 15 days to process the claim, due to matters beyond its control. If so, an extension will be permitted. In that event, the Company will send you a written delay notice:

(1) by the 15th day after receiving the first proof of claim; and
(2) every 30 days after that, until the claim is resolved.

The notice will explain:

(1) what additional information is needed to determine liability; and
(2) when a decision can be expected.

If you do not receive a written decision by the 105th day after the Company receives the first proof of claim, there is a right to an immediate review, as if the claim was denied.

Exception: The Company may need more information from you to process a claim. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. Within 180 days after receiving a denial notice, you may request a claim review by sending the Company:

(1) a written request; and
(2) any written comments or other items to support the claim.

You may review certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send you a written notice of its decision. The notice will state the reasons for the Company's decision, under the terms of the Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim, the notice will also describe:

(1) any further appeal procedures available under the Policy;
(2) the right to access relevant claim information; and
(3) the right to request a state insurance department review, or to bring legal action.

This notice will be sent within 45 days after the Company receives the request for review, or within 90 days if a special case requires more time.

Delay Notice. If the Company needs more than 45 days to process an appeal, in a special case:
(1) an extension of up to 45 more days will be permitted; and
(2) the Company will send you a written delay notice, by the 30th day after receiving the request for review.

The notice will explain:
(1) the special circumstances which require the delay;
(2) whether more information is needed to review the claim; and
(3) when a decision can be expected.

Exception: The Company may need more information from you to process an appeal. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under the Policy, the plan participant or beneficiary must first seek two administrative reviews of the adverse claim decision, in accord with this section. After the required reviews:
(1) an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
(2) the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

ERRORS RELATED TO THE INSURED PERSON'S COVERAGE. The Company has the right to correct benefit payments that are made in error. You, your Beneficiary or your estate has the responsibility to return any overpayments to the Company. The Company has the responsibility to make additional payments, if any underpayments have been made.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than five years after the date written proof of claim is required.

COMPANY'S DISCRETIONARY AUTHORITY. Except for the functions that the Policy clearly reserves to the Group Policyholder or Employer, the Company has the authority to manage the Policy, interpret its provisions, administer claims and resolve questions arising under it. The Company's authority includes (but is not limited to) the right to:
(1) establish administrative procedures, determine eligibility and resolve claims questions;
(2) determine what information the Company reasonably requires to make such decisions; and
(3) resolve all matters when an internal claim review is requested.
You have a right to request a state insurance department review or to bring legal action.
This provision does not apply to residents of California.

WEEKLY DISABILITY INCOME INSURANCE

TOTAL DISABILITY BENEFIT. The Company will pay a Weekly Total Disability Benefit for each week the Total Disability continues, if you:

(1) become Totally Disabled while insured for this benefit;
(2) are under the Regular Care of a Physician; and
(3) at your own expense, submit proof of continued Total Disability and Physician's care to the Company upon request.

Duration. Benefits start on the Day Benefits Begin, and end on the earliest of:

(1) the date you cease to be Totally Disabled or die;
(2) the date the Maximum Benefit Period ends; or
(3) the date you are able, but choose not to engage in Partial Disability Employment in your Own Occupation.

Proportional benefits will be paid for a partial week of Total Disability.

At the Company's option, benefits may also be denied or suspended on any of the following dates:

(1) the date you (without good cause):
    (a) fail to take a required medical exam;
    (b) fail to cooperate with an examiner; or
    (c) postpone a required exam more than twice;
(2) the 45th day after the Company requests additional proof, if not given; or
(3) the 45th day after the Company requests proof of your application for any Other Income Benefits to which you may be entitled (and which affect Policy benefits); if not given.

Amount. The amount of the Weekly Total Disability Benefit equals:

(1) your Basic Weekly Earnings multiplied by the Benefit Percentage (limited to the Maximum Weekly Benefit); minus
(2) Other Income Benefits.

The amount of the Weekly Total Disability Benefit will not be less than the Minimum Weekly Benefit, unless the Minimum Weekly Benefit plus Other Income Benefits would exceed 100% of your Basic Weekly Earnings.

The Day Benefits Begin, Maximum Benefit Period, Benefit Percentage, Maximum Weekly Benefit, and Minimum Weekly Benefit are shown in the Schedule of Insurance.

PARTIAL DISABILITY BENEFIT. The Company will pay a Weekly Partial Disability Benefit, if you:

(1) become Partially Disabled while insured for this benefit;
(2) are engaged in Partial Disability Employment;
(3) are earning at least 20% of Basic Weekly Earnings when Partial Disability Employment begins;
(4) are under the Regular Care of a Physician; and
(5) at your own expense, submit proof of continued Partial Disability, Physician's care and reduced earnings to the Company upon request.

You are not required to be Totally Disabled prior to receiving Weekly Partial Disability Benefits. The Day Benefits Begin may be reached by days of Total Disability, Partial Disability, or any combination of these. Proportional benefits will be paid for a partial week of Partial Disability.

Duration. Benefits start on the Day Benefits Begin, and will cease on the earliest of:

(1) the date you cease to be Partially Disabled or die;
(2) the date the Maximum Benefit Period ends;
(3) the date you earn more than 99% of Basic Weekly Earnings; or
(4) the date you are able, but choose not to work Full-Time or part-time in your Own Occupation.

At the Company's option, benefits may also be denied or suspended on any of the following dates:

(1) the date you (without good cause):
  (a) fail to take a required medical exam;
  (b) fail to cooperate with an examiner; or
  (c) postpone a required exam more than twice;
(2) the 45th day after the Company requests additional proof, if not given; or
(3) the 45th day after the Company requests proof of your application for Other Income Benefits to which you may be entitled (and which affect Policy benefits); if not given.

Amount. The amount of the Weekly Partial Disability Benefit equals the lesser of A or B below:

(A) (1) Your Basic Weekly Earnings multiplied by the Benefit Percentage (limited to the Maximum Weekly Benefit); minus
  (2) Other Income Benefits, except for earnings you receive from Partial Disability Employment; or
(B) Your Basic Weekly Earnings minus Other Income Benefits.

The amount of the Weekly Partial Disability Benefit will not be less than the Minimum Weekly Benefit, unless the Minimum Weekly Benefit plus Other Income Benefits would exceed 100% of your Basic Weekly Earnings.

The Day Benefits Begin, Maximum Benefit Period, Benefit Percentage, Maximum Weekly Benefit, and Minimum Weekly Benefit are shown in the Schedule of Insurance.

OTHER INCOME BENEFITS means Earnings, benefits, awards, or settlements from the following sources. These amounts will be offset, in determining your Weekly Benefit. Except for Retirement Benefits and Earnings, these amounts must result from the same Disability for which a Weekly Benefit is payable under the Policy.

Compulsory Benefits. Any disability income benefits you are eligible to receive under:
(1) state temporary disability income benefit laws;
(2) state no fault auto insurance laws; or
(3) any other compulsory benefit act or law (except Workers' Compensation and laws of like intent).

Other Insurance Plans. Any disability income benefits for which you are eligible under any no fault auto plan.

Employer's Retirement Plan. Any Disability Benefits or Retirement Benefits you receive under the Employer's Retirement Plan.

Social Security and other Government Retirement Plans. The following Social Security or other Government Retirement Plan benefits will be offset:
(1) **disability benefits** for which you and any spouse or child is eligible, because of your Disability;
(2) **unreduced retirement benefits** for which you and any spouse or child is eligible, because of your eligibility for unreduced retirement benefits; or
(3) **reduced retirement benefits** actually received by you and any spouse or child, because of your receipt of reduced retirement benefits.

As used above, **"Government Retirement Plans"** include disability and retirement benefits under:
(1) the federal Social Security Act, Jones Act or Railroad Retirement Act;
(2) the Canada Pension Plan or Quebec Pension Plan;
(3) any similar plan or act of any country, state, province or other political unit; or
(4) any plan provided in place of one of the above plans.

"Earnings", as used in this provision, means pay you earn or receive from any occupation or form of employment, as reported for federal income tax purposes. Earnings include (but are not limited to) a:
(1) salaried or hourly Employee's gross earnings (shown on Form W-2); including:
  (a) wages, tips, commissions, bonuses and overtime pay; and
  (b) any pre-tax contributions to a Section 125 Plan, flexible spending account, or qualified deferred compensation plan;
(2) proprietor's net profit (figured from Form 1040, Schedule C);
(3) professional corporation shareholder's net profit (figured from Form 1040, Schedule C);
(4) partner's net earnings from self-employment (shown on Schedule K-1) and any W-2 earnings; and
(5) Subchapter S Corporation shareholder's net earnings from trade or business activities (shown on Schedule K-1).

Recovery from Third Party. Any amount you recover from a third party as a result of the Disability (whether by judgment, settlement or otherwise). The offset:

(1) will be reduced by attorney fees and other reasonable costs of recovery; and
(2) will not exceed 100% of the net settlement.

Exceptions. The following will **not** be considered Other Income Benefits, and will not be offset in determining the Weekly Benefit:

(1) a cost-of-living increase in any Other Income Benefit (except Earnings); if it takes effect after the first offset for that benefit during a period of Disability;
(2) reimbursement for hospital, medical or surgical expense;
(3) reimbursement for attorney fees or other reasonable costs of claiming Other Income Benefits;
(4) group credit or mortgage disability insurance;
(5) early retirement benefits that are not elected or received under the federal Social Security Act or other Government Retirement Plan;
(6) any amounts under the Employer's Retirement Plan that:
    (a) represent your contributions; or
    (b) are received upon termination of employment without being disabled or retired;
(7) benefits from a 401(k), profit-sharing or thrift plan; an individual retirement account (IRA); a tax sheltered annuity (TSA); a stock ownership plan; or a non-qualified plan of deferred compensation;
(8) vacation pay, holiday pay, or severance pay; or
(9) disability income benefits under any individual policy, association group plan, franchise plan, or auto liability insurance policy (except no fault auto insurance).

RULES CONCERNING OTHER INCOME BENEFITS. If you may be entitled to Other Income Benefits that affect Policy benefits, you are required to actively claim them. For example, if Social Security or other Government Retirement Plan benefits may be payable, you:

(1) must promptly apply for such benefits; and, if denied
(2) must file an appeal or request an administrative hearing, upon Company request.

If you fail to promptly pursue such benefits, the Company has the option to deny or suspend Weekly Benefits or to reduce them by an estimated amount.

If Workers' Compensation or similar benefits may be payable for the same Disability, you and your Employer are required to cooperate in filing for those benefits. The Company will require proof of the denial or duration of those benefits to confirm its liability under the Policy.

Refunding Overpayments. Upon receiving Other Income Benefits, you must refund any resulting overpayment of Weekly Benefits under the Policy. If you do not promptly refund an overpayment to the Company within 60 days, in a lump sum, then:

(1) the Company will reduce or eliminate future payments; and
(2) the Minimum Weekly Benefit will not apply, until the amount is repaid.

Cost of Living Freeze. After the first deduction for each of the Other Income Benefits (except Earnings), its amount will be frozen. The Weekly Benefit will not be further reduced due to any cost-of-living increases payable under these Other Income Benefits.

RECURRENT DISABILITY. "Recurrent Disability" means a Disability caused by an Injury or Sickness which is the same as, or related to, the cause of a prior Disability for which Weekly Benefits were payable.

(1) A Recurrent Disability will be treated as a new period of Disability, if you:
   (a) have returned to your Own Occupation; and
   (b) have worked on a full-time basis, for two consecutive weeks or more.
   A new Day Benefits Begin and new Maximum Benefit Period will apply.

(2) A Recurrent Disability will be treated as part of the prior Disability, if you:
   (a) have returned to your Own Occupation; and
   (b) have worked on a full-time basis, for less than two consecutive weeks.
   The same Day Benefits Begin and same Maximum Benefit Period will apply to the Recurrent Disability as to the prior Disability.

To qualify for a Weekly Benefit for a Recurrent Disability, you must earn less than the percentage of Predisability Income specified in the Partial Disability Benefit section. Benefit payments will be subject to all other terms of the Policy that applied to the prior Disability.

This Recurrent Disability provision will cease to apply when you become eligible for coverage under any other group short-term disability policy.

EXCLUSIONS. Weekly Benefits will not be payable for any period of Disability:

(1) which is the result of an intentionally self-inflicted Injury or suicide attempt;
(2) during which you are not under the Regular Care of a Physician;
(3) which is the result of war (declared or undeclared) or any act of war;
(4) which is the result of a Sickness or Injury for which you receive benefits under Workers' Compensation or similar coverage;
(5) which arises out of (or in the course of) any employment for wage or profit, when the Disability would be covered by Workers' Compensation or similar coverage if:
   (a) the Employer had enrolled you for such coverage; and
   (b) you and your Employer had cooperated in filing a claim under that plan; or
(6) during which you receive payment under the Employer's Sick Leave or Salary Continuance Plan.

PRE-EXISTING CONDITION LIMITATION. The Policy will not cover any period of Disability:

(1) which is caused or contributed to by, or results from a Pre-Existing Condition; and
(2) which begins in the first 12 months after your Effective Date, unless you received no Treatment of the condition for 12 months in a row after your Effective Date.

"Pre-Existing Condition" means a Sickness or Injury for which you received Treatment within 3 months prior to your Effective Date.

"Treatment" means consultation, care and services by a Physician. It includes diagnostic measures and the prescription, refill and taking of prescribed drugs or medicines.

GENERAL PURPOSES AND LIMITATIONS OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION K.S.A.40-3001 et. seq.

DISCLAIMER

THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MAY NOT PROVIDE COVERAGE FOR ALL OR A PORTION OF THIS POLICY. IF COVERAGE IS PROVIDED, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS AND EXCLUSIONS, AND IS CONDITIONED UPON RESIDENCY IN THIS STATE. THEREFORE, YOU SHOULD NOT RELY UPON COVERAGE BY THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELECTING AN INSURANCE COMPANY OR IN SELECTING AN INSURANCE POLICY. INSURANCE COMPANIES AND THEIR AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELLING YOU ANY FORM OF AN INSURANCE POLICY, OR TO INDUCE YOU TO PURCHASE ANY FORM OF AN INSURANCE POLICY. EITHER THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE KANSAS INSURANCE DEPARTMENT WILL RESPOND TO ANY QUESTIONS YOU HAVE REGARDING THIS DOCUMENT.

Kansas Life and Health Insurance
Guaranty Association
2909 SW Maupin Lane
Topeka, KS 66614

Kansas Insurance Department
420 SW 9th Street
Topeka, KS 66612

This is a brief summary of the Kansas Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. If there is any inconsistency between this notice and Kansas law, then Kansas law will control.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Kansas law, with funding from assessments paid by other insurance companies. This safety net was created under Kansas law, which determines who and what is covered and the amounts of coverage. The basic protections provided by the Association are:

- Life Insurance

  $300,000 in death benefits

  $100,000 in cash surrender or withdrawal values

- Health Insurance

  $500,000 in hospital, medical and surgical insurance benefits

  $300,000 in disability insurance benefits

  $300,000 in long-term care insurance benefits

  $100,000 in other types of health insurance benefits

- Annuities

  $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits, as well as certain aggregate limits.

CERTIFICATE AMENDMENT

TO BE ATTACHED TO THE CERTIFICATE FOR GROUP POLICY NO.: 000010147074

ISSUED TO: USD 262 Valley Center Schools

Your Certificate is amended by adding the following provisions.

PRIOR INSURANCE CREDIT UPON TRANSFER OF
DISABILITY INCOME INSURANCE CARRIERS

This provision prevents loss of disability income coverage for you, which could otherwise occur solely because of a transfer of insurance carriers. The Policy will provide the following Prior Insurance Credit, when it replaces a prior plan.

"Prior Plan" means a prior carrier's group disability income policy, which the Policy replaced within 1 day of the prior plan's termination date.

FAILURE TO SATISFY ACTIVE WORK RULE. Subject to premium payments, the Policy will provide disability income coverage if you:

(1) were insured by the prior plan on its termination date; and
(2) were otherwise eligible under the Policy; but were not Actively-At-Work due to Injury or Sickness on its Effective Date.

AMOUNT OF COVERAGE. Until you satisfy the Policy's Active Work rule, your disability income coverage will not exceed that provided by the prior plan, had it remained in force. The Company will pay:

(1) the benefit the prior plan would have paid; minus
(2) any amount for which the prior carrier is liable.

DISABILITY DUE TO A PRE-EXISTING CONDITION. Benefits may be payable for a period of disability due to a Pre-Existing Condition if you:

(1) were insured by the prior plan on its termination date; and
(2) were Actively-At-Work and became insured under the Policy on its Effective Date.

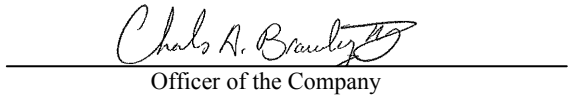
The benefits will be determined as follows:

A. The Company will apply the Policy's Pre-Existing Condition Limitation. If you qualify for benefits, you will be paid according to the Policy's benefit schedule.

B. If you cannot satisfy the Policy's Pre-Existing Condition Limitation; then the prior plan's pre-existing condition limitation will be applied, as follows:
   (1) If you satisfy the prior plan's pre-existing condition limitation, giving consideration towards continuous time insured under both policies; then benefits will be paid according to the prior plan's benefit schedule.
   (2) If you cannot satisfy the Pre-Existing Condition Limitation of the Policy, or that of the prior plan; then no benefit will be paid.

This Amendment takes effect on your effective date of coverage under the Policy. In all other respects, your Certificate remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

Lincoln Financial Group®

LINCOLN FINANCIAL GROUP® PRIVACY PRACTICES NOTICE

The Lincoln Financial Group companies* are committed to protecting your privacy. To provide the products and services you expect from a financial services leader, we must collect personal information about you. **We do not sell your personal information to third parties.** We share your personal information with third parties as necessary to provide you with the products or services you request and to administer your business with us. This Notice describes our current privacy practices. While your relationship with us continues, we will update and send our Privacy Practices Notice as required by law. Even after that relationship ends, we will continue to protect your personal information. **You do not need to take any action because of this Notice, but you do have certain rights as described below.**

INFORMATION WE MAY COLLECT AND USE

We collect personal information about you to help us identify you as our customer or our former customer; to process your requests and transactions; to offer investment or insurance services to you; to pay your claim; or to tell you about our products or services we believe you may want and use. The type of personal information we collect depends on the products or services you request and may include the following:

- **Information from you**: When you submit your application or other forms, you give us information such as your name, address, Social Security number; and your financial, health, and employment history.

- **Information about your transactions**: We keep information about your transactions with us, such as the products you buy from us; the amount you paid for those products; your account balances; and your payment history.

- **Information from outside our family of companies**: If you are purchasing insurance products, we may collect information from consumer reporting agencies such as your credit history; credit scores; and driving and employment records. With your authorization, we may also collect information, such as medical information from other individuals or businesses.

- **Information from your employer**: If your employer purchases group products from us, we may obtain information about you from your employer in order to enroll you in the plan.

HOW WE USE YOUR PERSONAL INFORMATION

We may share your personal information within our companies and with certain service providers. They use this information to process transactions you have requested; provide customer service; and inform you of products or services we offer that you may find useful. Our service providers may or may not be affiliated with us. They include financial service providers (for example, third party administrators; broker-dealers; insurance agents and brokers, registered representatives; reinsurers and other financial services companies with whom we have joint marketing agreements). Our service providers also include non-financial companies and individuals (for example, consultants; vendors; and companies that perform marketing services on our behalf). Information we obtain from a report prepared by a service provider may be kept by the service provider and shared with other persons; however, we require our service providers to protect your personal information and to use or disclose it only for the work they are performing for us, or as permitted by law.

When you apply for one of our products, we may share information about your application with credit bureaus. We also may provide information to group policy owners, regulatory authorities and law enforcement officials and to others when we believe in good faith that the law requires disclosure. In the event of a sale of all or part of our businesses, we may share customer information as part of the sale. **We do not sell or share your information with outside marketers who may want to offer you their own products and services; nor do we share information we receive about you from a consumer reporting agency. You do not need to take any action for this benefit.**

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

SECURITY OF INFORMATION

We have an important responsibility to keep your information safe. We use safeguards to protect your information from unauthorized disclosure. Our employees are authorized to access your information only when they need it to provide you with products, services, or to maintain your accounts. Employees who have access to your personal information are required to keep it confidential. Employees are trained on the importance of data privacy.

Questions about your personal information should be directed to:

Lincoln Financial Group
Attn: Enterprise Compliance and Ethics
Corporate Privacy Office, 7C-01
1300 S. Clinton St.
Fort Wayne, IN 46802

Please include all policy/contract/account numbers with your correspondence.

*This information applies to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company
Lincoln Financial Group Trust Company, LLC
Lincoln Financial Investment Services Corporation
Lincoln Investment Advisors Corporation
Lincoln Life & Annuity Company of New York
Lincoln Retirement Services Company, LLC
Lincoln Variable Insurance Products Trust
The Lincoln National Life Insurance Company

ADDITIONAL PRIVACY INFORMATION FOR INSURANCE PRODUCT CUSTOMERS

CONFIDENTIALITY OF MEDICAL INFORMATION

We understand that you may be especially concerned about the privacy of your medical information. We do not sell or rent your medical information to anyone; nor do we share it with others for marketing purposes. We only use and share your medical information for the purpose of underwriting insurance, administering your policy or claim and other purposes permitted by law, such as disclosure to regulatory authorities or in response to a legal proceeding.

MAKING SURE MEDICAL INFORMATION IS ACCURATE

We want to make sure we have accurate information about you. Upon written request we will tell you, within 30 business days, what personal information we have about you. You may see a copy of your personal information in person or receive a copy by mail, whichever you prefer. We will share with you who provided the information. In some cases we may provide your medical information to your personal physician. We will not provide you with information we have collected in connection with, or in anticipation of, a claim or legal proceeding. If you believe that any of our records are not correct, you may write and tell us of any changes you believe should be made. We will respond to your request within 30 business days. A copy of your request will be kept on file with your personal information so anyone reviewing your information in the future will be aware of your request. If we make changes to your records as a result of your request, we will notify you in writing and we will send the updated information, at your request, to any person who may have received the information within the prior two years. We will also send the updated information to any insurance support organization that gave us the information, and any service provider that received the information within the prior 7 years.

Questions about your personal medical information should be directed to:

Lincoln Financial Group
Attn: Medical Underwriting
P.O. Box 21008
Greensboro, NC 27420-1008

The CONFIDENTIALITY OF MEDICAL INFORMATION and MAKING SURE INFORMATION IS ACCURATE sections of this Notice apply to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company
Lincoln Life & Annuity Company of New York
The Lincoln National Life Insurance Company

The Lincoln National Life Insurance Company

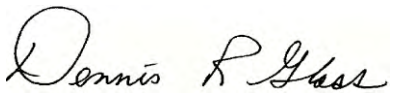
A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066 (402) 361-7300

CERTIFIES THAT Group Policy No. GL 000010147074 has been issued to
USD 262 Valley Center Schools
(The Group Policyholder)

The Issue Date of the Policy is October 1, 2011.

Certificate of Insurance for Class 4

You are entitled to the benefits described in this Certificate only if you are eligible, become and remain insured under the provisions of the Policy. This Certificate replaces any other certificates for the benefits described inside. As a Certificate of Insurance, it is not a contract of insurance; it only summarizes the provisions of the Policy and is subject to the Policy's terms. If the provisions of this Certificate and the Policy do not agree, the provisions of the Policy will apply.



President

CERTIFICATE OF GROUP INSURANCE
PROVIDING
WEEKLY DISABILITY INCOME INSURANCE

USD 262 Valley Center Schools
000010147074

SCHEDULE OF INSURANCE

CLASS 4

All Full-Time Employees Electing a 91/91/26 benefit

WAITING PERIOD: None (For date insurance begins, refer to "Effective Dates" section)

MINIMUM HOURS: 20 hours per week

WEEKLY DISABILITY INCOME INSURANCE

BENEFIT PERCENTAGE: 66 2/3%

MAXIMUM WEEKLY BENEFIT: $1,730

MINIMUM WEEKLY BENEFIT: 10% of your Weekly Total Disability Benefit

MAXIMUM BENEFIT PERIOD: 26 weeks

DAY BENEFITS BEGIN: 91st consecutive day of Disability due to accidental Injury; and
91st consecutive day of Disability due to Sickness.

The Day Benefits Begin may be reached by days of Total Disability, Partial Disability, or any combination thereof.

The Maximum Weekly Benefit will not exceed the Benefit Percentage times Basic Weekly Earnings.

After the Day Benefits Begin, the Maximum Benefit Period will be reduced by any days for which you receive payment under the Employer's Sick Leave or Salary Continuance Plan for the same Disability.

Weekly Disability Income Insurance will terminate when you retire.

The Policy does not replace or provide benefits required by Workers' Compensation laws or any state disability insurance plan laws.

CONTRIBUTIONS: You are required to contribute to the cost of the Weekly Disability Income Insurance.

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DEFINITIONS

As used throughout the Policy, the following terms shall have the meanings indicated below. Other parts of the Policy contain definitions specific to those provisions.

ACTIVE WORK or ACTIVELY AT WORK means your performance of all Main Duties of your Own Occupation, for the regularly scheduled number of hours, at:

(1) the Employer's place of business; or
(2) any other business location where the Employer requires you to travel.

Unless disabled on the prior workday or on the day of absence, you will be considered Actively at Work on the following days:

(1) a Saturday, Sunday or holiday that is not a scheduled workday;
(2) a paid vacation day, or other scheduled or unscheduled non-workday; or
(3) a non-medical leave of absence of 12 weeks or less, whether taken with the Employer's prior approval or on an emergency basis.

This includes a Military Leave or an approved Family or Medical Leave that is not due to your own health condition.

BASIC WEEKLY EARNINGS or **PREDISABILITY INCOME** means your average weekly base salary or hourly pay from the Employer before taxes on the Determination Date. The **"Determination Date"** is the last day worked just prior to the date the Disability begins.

It does **not** include commissions, bonuses, overtime pay, or any other extra compensation. It does **not** include income from a source other than the Employer. It will not exceed the amount shown in the Employer's financial records, the amount for which premium has been paid, or the Maximum Covered Weekly Earnings permitted by the Policy; whichever is less. (Maximum Covered Weekly Earnings equals the Maximum Weekly Benefit divided by the Benefit Percentage shown in the Schedule of Insurance.) Exception: For purposes of determining the Partial Disability Weekly Benefit, Basic Weekly Earnings will not exceed the amount shown in the Employer's financial records.

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

DAY or **DATE** means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, standard time, at the Group Policyholder's place of business. When used with regard to effective dates, it means 12:01 a.m. When used with regard to termination dates, it means 12:00 midnight.

DISABILITY or DISABLED means Total Disability or Partial Disability.

DISABILITY BENEFIT, when used with the term Retirement Plan, means a benefit that:
(1) is payable under a Retirement Plan due to disability as defined in that plan; and
(2) does not reduce the benefits that would have been paid as Retirement Benefits at the normal retirement age under the plan if the disability had not occurred.

If the payment of the benefit does cause such a reduction, the benefit will be deemed a Retirement Benefit as defined in the Policy.

EMPLOYEE or FULL-TIME EMPLOYEE means a person:
(1) whose employment with the Employer is the person's main occupation;
(2) whose employment is for regular wage or salary;
(3) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Insurance per week;
(4) who is a member of an Eligible Class which is eligible for coverage under the Policy;
(5) who is not a temporary or seasonal employee; and
(6) who is a citizen of the United States or legally works in the United States.

EMPLOYER means the Group Policyholder. It includes any division, subsidiary or affiliated company named in the Application or Participation Agreement.

EVIDENCE OF INSURABILITY means a statement of proof of your medical history. The Company uses this to determine your acceptance for insurance or an increased amount of insurance. Such proof will be provided at your own expense.

FAMILY OR MEDICAL LEAVE means an approved leave of absence that:
(1) is subject to the federal FMLA law (the Family and Medical Leave Act of 1993 and any amendments to it) or a similar state law;
(2) is taken in accord with the Employer's leave policy and the law which applies; and
(3) does not exceed the period approved by the Employer and required by that law.

Under the federal FMLA law, such leaves are permitted for up to 12 weeks in a 12-month period as defined by the Employer. The 12 weeks:
(1) may consist of consecutive or intermittent work days; or
(2) may be granted on a part-time equivalency basis.

If you are entitled to a leave under both the federal FMLA law and a similar state law, you may elect the more favorable leave (but not both). If you are on an FMLA leave due to your own health condition on the date Policy coverage takes effect, you are not considered Actively at Work.

FULL-TIME, as it applies to the Partial Disability Benefit, means the average number of hours you were regularly scheduled to work, at your Own Occupation, during the week just prior to:
(1) the date Disability begins; or
(2) the date an approved leave of absence begins, if Disability begins while you are continuing coverage during a leave of absence.

GROUP POLICYHOLDER means the person, company, trust or other organization as shown on the Title Page of the Policy.

INJURY means bodily Injury which results directly from an accident, independently of all other causes. In determining Weekly Benefits, a Disability will be considered caused by a Sickness if:
(1) the Disability begins more than 60 days after the Injury; or
(2) the Injury occurred before your Effective Date under the Policy.

The term "Injury" shall not include any:
(1) condition to which a Sickness, its natural progression or its treatment is a substantial contributing cause (based upon the preponderance of medical evidence);
(2) condition caused by emotional stress or trauma; infection (except pyogenic bacterial infection of an Injury); or medical or surgical treatment (except when needed solely for an Injury);
(3) repetitive trauma condition which results from repetitious, physically traumatic activities that occur over time; or
(4) pregnancy; except for complications that result from an Injury.

INSURANCE MONTH or **POLICY MONTH** means that period of time:
(1) beginning at 12:01 a.m. Standard Time, at the Group Policyholder's place of business on the first day of any calendar month; and
(2) ending at 12:00 midnight on the last day of the same calendar month.

INSURED PERSON means a Person for whom Policy coverage is in effect.

MAIN DUTIES or **MATERIAL AND SUBSTANTIAL DUTIES** means those job tasks that:
(1) are normally required to perform your Own Occupation; and
(2) could not reasonably be modified or omitted.

To determine whether a job task could reasonably be modified or omitted, the Company will apply the Americans with Disabilities Act's standards concerning reasonable accommodation. It will apply the Act's standards, whether or not:
(1) the Employer is subject to the Act; or
(2) you have requested such a job accommodation.
An Employer's failure to modify or omit other job tasks does **not** render you unable to perform the Main Duties of the job.

Main Duties include those job tasks:
(1) as described in the U.S. Department of Labor Dictionary of Occupational Titles; and
(2) as performed in the general labor market and national economy.
Main Duties are **not** limited to those specific job tasks as performed for a certain firm or at a certain work site.

MEDICALLY APPROPRIATE TREATMENT means diagnostic services, consultation, care or services that are consistent with the symptoms or diagnosis causing your Disability. Such treatment must be rendered:
(1) by a Physician whose license and any specialty are consistent with the disabling condition; and
(2) according to generally accepted, professionally recognized standards of medical practice.

MILITARY LEAVE means a leave of absence that:
(1) is subject to the federal USERRA law (the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it);
(2) is taken in accord with the Employer's leave policy and the federal USERRA law; and
(3) does not exceed the period required by that law.

OWN OCCUPATION or **REGULAR OCCUPATION** means the occupation, trade or profession:
(1) in which you were employed with the Employer prior to Disability; and
(2) which was your main source of earned income prior to Disability.

It means a collective description of related jobs, as defined by the U.S. Department of Labor Dictionary of Occupational Titles. It includes any work in the same occupation for pay or profit, regardless of:
(1) whether such work is with the Employer, with some other firm, or on a self-employed basis; or
(2) whether a suitable opening is currently available with the Employer or in the local labor market.

PARTIAL DISABILITY or **PARTIALLY DISABLED** means that, due to an Injury or Sickness, you:
(1) are unable to perform one or more of the Main Duties of your Own Occupation, or are unable to perform such duties Full-Time; and
(2) are engaged in Partial Disability Employment.

PARTIAL DISABILITY EMPLOYMENT means you are working at your Own Occupation or any other occupation; however, because of a Partial Disability:
(1) your hours or production is reduced;
(2) one or more Main Duties of the job are reassigned; or
(3) you are working in a lower-paid occupation.

During Partial Disability Employment, your current earnings:
(1) must be at least 20% of Predisability Income; and
(2) may not exceed the percentage specified in the Partial Disability Benefit section.

PERSON means an Employee of the Employer:
(1) who is a member of an Employee class which is eligible for coverage under the Policy; and
(2) who has completed an enrollment form.

PERSONAL INSURANCE means the insurance provided by the Policy on Insured Persons.

PHYSICIAN means:
(1) a legally qualified medical doctor who is licensed to practice medicine, to prescribe and administer drugs, or to perform surgery; or
(2) any other duly licensed medical practitioner who is deemed by state law to be the same as a legally qualified medical doctor.

The medical doctor or other medical practitioner must be acting within the scope of his or her license. He or she must be qualified to provide Medically Appropriate Treatment for your disabling condition.

Physician does **not** include you or your relatives. Relatives include:
(1) your spouse, siblings, parents, children and grandparents; and
(2) your spouse's relatives of like degree.

POLICY means the group insurance Policy issued by the Company to the Group Policyholder.

PREDISABILITY INCOME--See Basic Weekly Earnings definition.

REGULAR CARE OF A PHYSICIAN means you:
(1) personally visit a Physician, as often as medically required according to standard medical practice to effectively manage and treat your disabling condition; and
(2) receive Medically Appropriate Treatment, by a Physician whose license and any specialty are consistent with the disabling condition.

REGULAR OCCUPATION--See Own Occupation or Regular Occupation definition.

RETIREMENT BENEFIT, when used with the term Retirement Plan, means a benefit that:
(1) is payable under a Retirement Plan either in a lump sum or in the form of periodic payments;
(2) does not represent contributions made by you (Payments representing Employee contributions are deemed to be received over your expected remaining life, regardless of when they are actually received.); and
(3) is payable upon:
    (a) early or normal retirement; or
    (b) disability (if the payment does reduce the benefit which would have been paid at the normal retirement age under the plan, if disability had not occurred).

RETIREMENT PLAN means a defined benefit or defined contribution plan that:
(1) provides Retirement Benefits to Employees; and
(2) is not funded wholly by Employee contributions.

The term shall not include any 401(k), profit-sharing or thrift plan; informal salary continuance plan; individual retirement account (IRA); tax sheltered annuity (TSA); stock ownership plan; or a non-qualified plan of deferred compensation.

An Employer's Retirement Plan is deemed to include any Retirement Plan:
(1) which is part of any federal, state, county, municipal or association retirement system; and
(2) for which you are eligible as a result of employment with the Employer.

SICK LEAVE or **SALARY CONTINUANCE PLAN** means a plan that:

(1) is established and maintained by the Employer for the benefit of Employees; and
(2) continues payment of all or part of your Predisability Income for a specified period after you become Disabled.

It does **not** include compensation the Employer pays you for work actually performed during a Disability.

SICKNESS means illness, pregnancy or disease.

TOTAL DISABILITY or **TOTALLY DISABLED** means your inability, due to Sickness or Injury, to perform each of the Main Duties of your Own Occupation. A Person engaging in any employment for wage or profit is not Totally Disabled. The loss of a professional license, an occupational license or certification, or a driver's license for any reason does **not**, by itself, constitute Total Disability.

WAITING PERIOD means the period of time you must be employed in an eligible class with the Employer, before you become eligible to enroll for coverage under the Policy. The period of service must be continuous, except as explained in the Eligibility provision captioned Prior Service Credit Towards Waiting Period.

WEEKLY BENEFIT means the amount payable weekly by the Company to you while you are Totally Disabled or Partially Disabled.

WORKERS' COMPENSATION OR SIMILAR COVERAGE means coverage under a law that compensates for job related Injury or Sickness. It includes (but is not limited to):

(1) coverage under any Workers' Compensation or occupational disease law;
(2) coverage under the Jones Act; the Longshoreman's and Harbor Worker's Act; the Maritime Doctrine of Maintenance, Wages or Cure; or
(3) any plan provided in place of one of those plans.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties shall consist of:
(1) the Policy and any amendments to it;
(2) the Group Policyholder's application (a copy of which is attached to the Policy);
(3) any Participating Employers' applications or Participation Agreements; and
(4) any individual applications of Insured Persons.

In the absence of fraud, all statements made by the Group Policyholder and by Insured Persons are representations and not warranties. No statement made by an Insured Person will be used to contest the coverage provided by the Policy, unless:
(1) it is contained in a written statement signed by that Insured Person; and
(2) a copy of the statement has been furnished to that Insured Person.

Only an Officer of the Company may change this Policy or extend the time for payment of any premium. No change will be valid unless made in writing and signed by an Officer of the Company. Any change so made will be binding on all persons referred to in the Policy.

INCONTESTABILITY. Except for the non-payment of premiums or fraud, the Company may not contest the validity of the Policy after it has been in force for two years from its date of issue; and as to any Insured Person, after his or her coverage has been in force for two years during his or her lifetime. This clause does not preclude, at any time, the assertion of defenses based upon:
(1) the Policy's eligibility requirements, exclusions and limitations; and
(2) other Policy provisions unrelated to the validity of coverage.

RESCISSION. The Company has the right to rescind any insurance for which Evidence of Insurability was required, if:
(1) you incur a claim during the first two years of coverage; and
(2) the Company discovers that you made a Material Misrepresentation on your application.

A **"Material Misrepresentation"** is an incomplete or untrue statement that caused the Company to issue coverage that it would have disapproved, had it known the truth. No misrepresentation is material unless the statement misrepresented actually contributes to the contingency or event on which the coverage is to become due and payable. **"To rescind"** means to cancel insurance back to its effective date. In that event, the Company will refund all premium paid for the rescinded insurance, less any benefits paid for your claims. The Company reserves the right to recover any claims paid in excess of such premiums.

MISSTATEMENTS OF FACTS. If relevant facts about any Person were misstated:
(1) a fair adjustment of the premium will be made; and
(2) the true facts will decide if and in what amount insurance is valid under the Policy.
If your age has been misstated, any benefits shall be in the amount the paid premium would have purchased at the correct age.

GROUP POLICYHOLDER'S AGENCY. For all purposes of the Policy, the Group Policyholder acts on its own behalf or as an agent of the Insured Person. Under no circumstances will the Group Policyholder be deemed the agent of the Company.

CURRENCY. In administering the Policy:
(1) all Predisability Income will be expressed in U.S. dollars; and
(2) all premium and benefits must be paid in U.S. dollars.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE. The Policy does not replace or provide benefits required by:
(1) Workers' Compensation laws; or
(2) any state temporary disability insurance plan laws.

ASSIGNMENT. The rights and benefits under this Certificate may not be assigned.

ELIGIBILITY AND EFFECTIVE DATES

ELIGIBLE CLASSES. The classes of Employees eligible for insurance are shown in the Schedule of Insurance. The Company has the right to review and terminate any or all classes eligible under the Policy, if any class ceases to be covered by the Policy.

ELIGIBILITY. A Person becomes eligible for coverage provided by the Policy on the later of:
(1) the Policy's date of issue; or
(2) the date the Waiting Period is completed.

Prior Service Credit Towards Waiting Period. The Waiting Period is shown in the Schedule of Insurance. Prior service in an Eligible Class will apply toward the Waiting Period, when:
(1) you are a former Employee and are rehired within one year after your employment ends;
(2) you return from an approved Family or Medical Leave within:
  (a) the 12-week period required by federal law; or
  (b) any longer period required by a similar state law; or
(3) you return from a Military Leave within the period required by federal USERRA law.

EFFECTIVE DATE. Your initial amount of Personal Insurance becomes effective at 12:01 a.m. on the latest of:
(1) the first day of the Insurance Month following the date you become eligible for the coverage;
(2) the date you resume Active Work, if not Actively at Work on the day you become eligible;
(3) the date you make written application for coverage and sign:
  (a) a payroll deduction order, if you pay any part of the Policy premiums; or
  (b) an order to pay premiums from your Flexible Benefits Plan account, if Employer contributions are made through such an account; or
(4) the date the Company approves your Evidence of Insurability, if required.

Any increased or additional coverage becomes effective at 12:01 a.m. on the latest of:
(1) the first day of the Insurance Month coinciding with or next following the day on which you become eligible for the increase, if Actively at Work on that day;
(2) the date you resume Active Work, if not Actively at Work on the day the increase would otherwise take effect; or
(3) the date any required Evidence of Insurability is approved by the Company.

Any decrease will take effect on the day of the change, whether or not you are Actively at Work.

Evidence of Insurability. Evidence of Insurability satisfactory to the Company must be submitted (at your expense) when:
(1) you make written application for coverage (or an increased amount of coverage) more than 31 days after becoming eligible for the coverage; or
(2) you make written application for coverage after you have requested:
  (a) to cancel insurance;
  (b) to stop payroll deductions for the insurance; or
  (c) to stop premium payments from the Flexible Benefits Plan account.

Effective Date for Change in Eligible Class. You may become a member of a different Eligible Class. Coverage under the different Eligible Class will be effective:
(1) on the first day of the Insurance Month coinciding with or next following the date of the change;
(2) except as stated in the Effective Date provision for increases or decreases.

ELIGIBILITY AND EFFECTIVE DATES
(Continued)

REINSTATEMENT RIGHTS. If your coverage terminates due to one of the following breaks in service, you will be entitled to reinstate the coverage upon resuming Active Work with the Employer within the required timeframe. **"Reinstatement"** or **"to reinstate"** means to re-enroll for Policy coverage, without satisfying a new Waiting Period or providing Evidence of Insurability. Reinstatement is available upon:

(1) return from an approved Family or Medical Leave within:
  (a) the 12-week period required by federal law; or
  (b) any longer period required by a similar state law;
(2) return from a Military Leave within the period required by federal USERRA law;
(3) return from any other approved leave of absence within six months after the leave begins;
(4) return within 12 months following a lay off; or
(5) return within 12 months following termination of employment for any other reason.

To reinstate coverage, you must apply for coverage or be re-enrolled within 31 days after resuming Active Work in an Eligible Class. The reinstated amount of insurance may not exceed the amount that terminated. Reinstatement will take effect on the date you return to Active Work.

If the above conditions are met, and the Policy includes a Pre-Existing Condition Exclusion, then:

(1) the months of leave will count towards any unmet Pre-Existing Condition Exclusion period; and
(2) a new Pre-Existing Condition Exclusion will not apply to the reinstated amount of insurance.

A new Pre-Existing Condition Exclusion will apply to any increased amount of insurance.

INDIVIDUAL TERMINATIONS

TERMINATION OF COVERAGE. Your coverage will terminate at 12:00 midnight on the earliest of:

(1) the date the Policy terminates or the Employer's participation ends (but without prejudice to any claim incurred prior to termination);
(2) the date your class is no longer eligible for insurance;
(3) the date you cease to be a member of an Eligible Class;
(4) the last day of the Insurance Month in which you request termination;
(5) the last day of the last Insurance Month for which premium payment is made on your behalf;
(6) the end of the period for which the last required premium has been paid;
(7) with respect to any particular insurance benefit, the day the portion of the Policy providing that benefit terminates;
(8) the date your employment with the Group Policyholder or Participating Employer terminates (unless coverage is continued as provided below); or
(9) the date you enter the armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard. (If you send proof of military service, the Company will refund any unearned premium.)

CONTINUATION RIGHTS. Ceasing Active Work results in termination of your eligibility for coverage, but coverage may be continued as follows.

Disability. If you are absent due to Total Disability or engaged in Partial Disability Employment, coverage may be continued:

(1) until the Day Benefits Begin; and
(2) during the period for which benefits are payable.

The Company must receive the required premium from the Employer.

INDIVIDUAL TERMINATIONS
(Continued)

Family or Medical Leave. If you go on an approved Family or Medical Leave and are **not** entitled to the more favorable continuation available during Disability, coverage may be continued until the earliest of:

(1) the end of the leave period approved by the Employer;
(2) the end of the 12-week leave period required by federal law, or any more favorable period required by a similar state law;
(3) the date you notify the Employer that you will not return; or
(4) the date you begin employment with another employer.

The required premium payments must be received from the Employer, throughout the period of continued coverage.

Military Leave. If you go on a Military Leave, coverage may be continued for the same period allowed for an approved Family or Medical Leave. The required premium payments must be received from the Employer, throughout the period of continued coverage.

Lay Off or Other Leave. If you cease work due to a temporary lay off, or due to an approved leave of absence (other than an approved Family or Medical Leave or a Military Leave); coverage may be continued for three Insurance Months after the lay off or leave begins. The required premium payments must be received from the Employer, throughout the period of continued coverage.

Conditions. In administering the above continuations, the Employer must not act so as to discriminate unfairly among Insured Persons in similar situations. Insurance may **not** be continued when you cease Active Work due to a labor dispute, strike, work slowdown or lockout.

INDIVIDUAL TERMINATION DURING DISABILITY. Termination of your coverage during a Disability will have no effect on benefits payable for that period of Disability.

CLAIMS PROCEDURES
FOR WEEKLY DISABILITY INCOME BENEFITS

NOTICE AND PROOF OF CLAIM -- Notice of Claim. Written notice of a Disability claim must be given:
(1) within 20 days after the Injury or Sickness causing Disability begins; or
(2) as soon as reasonably possible after that.*
The notice must be sent to the Company's Group Insurance Service Office. It should include your name and address, and the number of the Policy.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days, you may send the Company written proof of Disability in a letter. It should state the date the Disability began, its cause and degree. The Company will periodically send you additional claim forms.

Proof of Claim. The Company must be given written proof of a Disability claim:
(1) within 90 days after the Day Benefits Begin; or
(2) as soon as reasonably possible after that.*

Proof of claim must be provided at your own expense. It must show the date the Disability began, its cause and degree. Documentation must include the following:
(1) completed statements by you and your Employer;
(2) a completed statement by the attending Physician, which must describe any restrictions on the performance of the duties of your Regular Occupation;
(3) proof of any other income received, and of any other benefits available from other income sources, which may affect Policy benefits;
(4) a signed authorization for the Company to obtain more information; and
(5) any other items the Company may reasonably require in support of the claim.

Proof of continued Disability, Regular Care of a Physician, and any Other Income Benefits affecting the claim must be given to the Company. This must be supplied within 45 days after the Company requests it. If it is not, benefits may be denied or suspended.

***Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim, if it is shown that it was done:
(1) as soon as reasonably possible; and
(2) in no event more than one year after it was required.
These time limits will not apply while you lack legal capacity.

EXAMINATION. The Company may have you examined:
(1) by a Physician, specialist or vocational rehabilitation expert of the Company's choice;
(2) as often as reasonably required while a claim or appeal is pending.

Any such exam will be at the Company's expense.

The Company may determine that (in its opinion) you have:
(1) failed to cooperate with an examiner;
(2) failed to take an exam scheduled by the Company; or
(3) postponed such an exam more than twice.
In that event, benefits may be denied or suspended, until the required exam is completed.

CLAIMS PROCEDURES
(Continued)

TIME OF PAYMENT OF CLAIMS. Weekly Disability Income Benefits payable under the Policy will be paid immediately after the Company receives complete proof of claim and confirms liability. Such benefits will be paid biweekly, during any period for which the Company is liable. If benefits are due for less than a week, they will be paid on a pro rata basis. The daily rate will equal 1/7 of the Weekly Benefit. Any balance, which remains unpaid at the end of the period of liability, will be paid immediately after the Company receives complete proof of claim and confirms liability.

TO WHOM PAYABLE. All Weekly Disability Income Benefits are payable to you, while living. After your death, such benefits will be payable to your estate.

NOTICE OF CLAIM DECISION. The Company will send you a written notice of its claim decision. If the Company denies any part of the claim, the written notice will explain:

(1) the reason for the denial, under the terms of the Policy and any internal guidelines;
(2) how you may request a review of the Company's decision; and
(3) whether more information is needed to support the claim.

This notice will be sent within 15 days after the Company resolves the claim. It will be sent within 45 days after the Company receives the first proof of claim, if reasonably possible.

Delay Notice. The Company may need more than 15 days to process the claim, due to matters beyond its control. If so, an extension will be permitted. In that event, the Company will send you a written delay notice:

(1) by the 15th day after receiving the first proof of claim; and
(2) every 30 days after that, until the claim is resolved.

The notice will explain:

(1) what additional information is needed to determine liability; and
(2) when a decision can be expected.

If you do not receive a written decision by the 105th day after the Company receives the first proof of claim, there is a right to an immediate review, as if the claim was denied.

Exception: The Company may need more information from you to process a claim. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. Within 180 days after receiving a denial notice, you may request a claim review by sending the Company:

(1) a written request; and
(2) any written comments or other items to support the claim.

You may review certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send you a written notice of its decision. The notice will state the reasons for the Company's decision, under the terms of the Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim, the notice will also describe:

(1) any further appeal procedures available under the Policy;
(2) the right to access relevant claim information; and
(3) the right to request a state insurance department review, or to bring legal action.

This notice will be sent within 45 days after the Company receives the request for review, or within 90 days if a special case requires more time.

Delay Notice. If the Company needs more than 45 days to process an appeal, in a special case:
(1) an extension of up to 45 more days will be permitted; and
(2) the Company will send you a written delay notice, by the 30th day after receiving the request for review.

The notice will explain:
(1) the special circumstances which require the delay;
(2) whether more information is needed to review the claim; and
(3) when a decision can be expected.

Exception: The Company may need more information from you to process an appeal. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under the Policy, the plan participant or beneficiary must first seek two administrative reviews of the adverse claim decision, in accord with this section. After the required reviews:
(1) an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
(2) the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

ERRORS RELATED TO THE INSURED PERSON'S COVERAGE. The Company has the right to correct benefit payments that are made in error. You, your Beneficiary or your estate has the responsibility to return any overpayments to the Company. The Company has the responsibility to make additional payments, if any underpayments have been made.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than five years after the date written proof of claim is required.

COMPANY'S DISCRETIONARY AUTHORITY. Except for the functions that the Policy clearly reserves to the Group Policyholder or Employer, the Company has the authority to manage the Policy, interpret its provisions, administer claims and resolve questions arising under it. The Company's authority includes (but is not limited to) the right to:
(1) establish administrative procedures, determine eligibility and resolve claims questions;
(2) determine what information the Company reasonably requires to make such decisions; and
(3) resolve all matters when an internal claim review is requested.
You have a right to request a state insurance department review or to bring legal action.
This provision does not apply to residents of California.

WEEKLY DISABILITY INCOME INSURANCE

TOTAL DISABILITY BENEFIT. The Company will pay a Weekly Total Disability Benefit for each week the Total Disability continues, if you:

(1) become Totally Disabled while insured for this benefit;
(2) are under the Regular Care of a Physician; and
(3) at your own expense, submit proof of continued Total Disability and Physician's care to the Company upon request.

Duration. Benefits start on the Day Benefits Begin, and end on the earliest of:

(1) the date you cease to be Totally Disabled or die;
(2) the date the Maximum Benefit Period ends; or
(3) the date you are able, but choose not to engage in Partial Disability Employment in your Own Occupation.

Proportional benefits will be paid for a partial week of Total Disability.

At the Company's option, benefits may also be denied or suspended on any of the following dates:

(1) the date you (without good cause):
    (a) fail to take a required medical exam;
    (b) fail to cooperate with an examiner; or
    (c) postpone a required exam more than twice;
(2) the 45th day after the Company requests additional proof, if not given; or
(3) the 45th day after the Company requests proof of your application for any Other Income Benefits to which you may be entitled (and which affect Policy benefits); if not given.

Amount. The amount of the Weekly Total Disability Benefit equals:

(1) your Basic Weekly Earnings multiplied by the Benefit Percentage (limited to the Maximum Weekly Benefit); minus
(2) Other Income Benefits.

The amount of the Weekly Total Disability Benefit will not be less than the Minimum Weekly Benefit, unless the Minimum Weekly Benefit plus Other Income Benefits would exceed 100% of your Basic Weekly Earnings.

The Day Benefits Begin, Maximum Benefit Period, Benefit Percentage, Maximum Weekly Benefit, and Minimum Weekly Benefit are shown in the Schedule of Insurance.

PARTIAL DISABILITY BENEFIT. The Company will pay a Weekly Partial Disability Benefit, if you:

(1) become Partially Disabled while insured for this benefit;
(2) are engaged in Partial Disability Employment;
(3) are earning at least 20% of Basic Weekly Earnings when Partial Disability Employment begins;
(4) are under the Regular Care of a Physician; and
(5) at your own expense, submit proof of continued Partial Disability, Physician's care and reduced earnings to the Company upon request.

You are not required to be Totally Disabled prior to receiving Weekly Partial Disability Benefits. The Day Benefits Begin may be reached by days of Total Disability, Partial Disability, or any combination of these. Proportional benefits will be paid for a partial week of Partial Disability.

Duration. Benefits start on the Day Benefits Begin, and will cease on the earliest of:

(1) the date you cease to be Partially Disabled or die;
(2) the date the Maximum Benefit Period ends;
(3) the date you earn more than 99% of Basic Weekly Earnings; or
(4) the date you are able, but choose not to work Full-Time or part-time in your Own Occupation.

At the Company's option, benefits may also be denied or suspended on any of the following dates:

(1) the date you (without good cause):
  (a) fail to take a required medical exam;
  (b) fail to cooperate with an examiner; or
  (c) postpone a required exam more than twice;
(2) the 45th day after the Company requests additional proof, if not given; or
(3) the 45th day after the Company requests proof of your application for Other Income Benefits to which you may be entitled (and which affect Policy benefits); if not given.

Amount. The amount of the Weekly Partial Disability Benefit equals the lesser of A or B below:

(A) (1) Your Basic Weekly Earnings multiplied by the Benefit Percentage (limited to the Maximum Weekly Benefit); minus
  (2) Other Income Benefits, except for earnings you receive from Partial Disability Employment; or
(B) Your Basic Weekly Earnings minus Other Income Benefits.

The amount of the Weekly Partial Disability Benefit will not be less than the Minimum Weekly Benefit, unless the Minimum Weekly Benefit plus Other Income Benefits would exceed 100% of your Basic Weekly Earnings.

The Day Benefits Begin, Maximum Benefit Period, Benefit Percentage, Maximum Weekly Benefit, and Minimum Weekly Benefit are shown in the Schedule of Insurance.

OTHER INCOME BENEFITS means Earnings, benefits, awards, or settlements from the following sources. These amounts will be offset, in determining your Weekly Benefit. Except for Retirement Benefits and Earnings, these amounts must result from the same Disability for which a Weekly Benefit is payable under the Policy.

Compulsory Benefits. Any disability income benefits you are eligible to receive under:
(1) state temporary disability income benefit laws;
(2) state no fault auto insurance laws; or
(3) any other compulsory benefit act or law (except Workers' Compensation and laws of like intent).

Other Insurance Plans. Any disability income benefits for which you are eligible under any no fault auto plan.

Employer's Retirement Plan. Any Disability Benefits or Retirement Benefits you receive under the Employer's Retirement Plan.

Social Security and other Government Retirement Plans. The following Social Security or other Government Retirement Plan benefits will be offset:
(1) **disability benefits** for which you and any spouse or child is eligible, because of your Disability;
(2) **unreduced retirement benefits** for which you and any spouse or child is eligible, because of your eligibility for unreduced retirement benefits; or
(3) **reduced retirement benefits** actually received by you and any spouse or child, because of your receipt of reduced retirement benefits.

As used above, **"Government Retirement Plans"** include disability and retirement benefits under:
(1) the federal Social Security Act, Jones Act or Railroad Retirement Act;
(2) the Canada Pension Plan or Quebec Pension Plan;
(3) any similar plan or act of any country, state, province or other political unit; or
(4) any plan provided in place of one of the above plans.

"Earnings", as used in this provision, means pay you earn or receive from any occupation or form of employment, as reported for federal income tax purposes. Earnings include (but are not limited to) a:
(1) salaried or hourly Employee's gross earnings (shown on Form W-2); including:
  (a) wages, tips, commissions, bonuses and overtime pay; and
  (b) any pre-tax contributions to a Section 125 Plan, flexible spending account, or qualified deferred compensation plan;
(2) proprietor's net profit (figured from Form 1040, Schedule C);
(3) professional corporation shareholder's net profit (figured from Form 1040, Schedule C);
(4) partner's net earnings from self-employment (shown on Schedule K-1) and any W-2 earnings; and
(5) Subchapter S Corporation shareholder's net earnings from trade or business activities (shown on Schedule K-1).

Recovery from Third Party. Any amount you recover from a third party as a result of the Disability (whether by judgment, settlement or otherwise). The offset:

(1) will be reduced by attorney fees and other reasonable costs of recovery; and
(2) will not exceed 100% of the net settlement.

Exceptions. The following will **not** be considered Other Income Benefits, and will not be offset in determining the Weekly Benefit:

(1) a cost-of-living increase in any Other Income Benefit (except Earnings); if it takes effect after the first offset for that benefit during a period of Disability;
(2) reimbursement for hospital, medical or surgical expense;
(3) reimbursement for attorney fees or other reasonable costs of claiming Other Income Benefits;
(4) group credit or mortgage disability insurance;
(5) early retirement benefits that are not elected or received under the federal Social Security Act or other Government Retirement Plan;
(6) any amounts under the Employer's Retirement Plan that:
    (a) represent your contributions; or
    (b) are received upon termination of employment without being disabled or retired;
(7) benefits from a 401(k), profit-sharing or thrift plan; an individual retirement account (IRA); a tax sheltered annuity (TSA); a stock ownership plan; or a non-qualified plan of deferred compensation;
(8) vacation pay, holiday pay, or severance pay; or
(9) disability income benefits under any individual policy, association group plan, franchise plan, or auto liability insurance policy (except no fault auto insurance).

RULES CONCERNING OTHER INCOME BENEFITS. If you may be entitled to Other Income Benefits that affect Policy benefits, you are required to actively claim them. For example, if Social Security or other Government Retirement Plan benefits may be payable, you:

(1) must promptly apply for such benefits; and, if denied
(2) must file an appeal or request an administrative hearing, upon Company request.

If you fail to promptly pursue such benefits, the Company has the option to deny or suspend Weekly Benefits or to reduce them by an estimated amount.

If Workers' Compensation or similar benefits may be payable for the same Disability, you and your Employer are required to cooperate in filing for those benefits. The Company will require proof of the denial or duration of those benefits to confirm its liability under the Policy.

Refunding Overpayments. Upon receiving Other Income Benefits, you must refund any resulting overpayment of Weekly Benefits under the Policy. If you do not promptly refund an overpayment to the Company within 60 days, in a lump sum, then:

(1) the Company will reduce or eliminate future payments; and
(2) the Minimum Weekly Benefit will not apply, until the amount is repaid.

Cost of Living Freeze. After the first deduction for each of the Other Income Benefits (except Earnings), its amount will be frozen. The Weekly Benefit will not be further reduced due to any cost-of-living increases payable under these Other Income Benefits.

RECURRENT DISABILITY. "Recurrent Disability" means a Disability caused by an Injury or Sickness which is the same as, or related to, the cause of a prior Disability for which Weekly Benefits were payable.

(1) A Recurrent Disability will be treated as a new period of Disability, if you:
   (a) have returned to your Own Occupation; and
   (b) have worked on a full-time basis, for two consecutive weeks or more.
   A new Day Benefits Begin and new Maximum Benefit Period will apply.

(2) A Recurrent Disability will be treated as part of the prior Disability, if you:
   (a) have returned to your Own Occupation; and
   (b) have worked on a full-time basis, for less than two consecutive weeks.
   The same Day Benefits Begin and same Maximum Benefit Period will apply to the Recurrent Disability as to the prior Disability.

To qualify for a Weekly Benefit for a Recurrent Disability, you must earn less than the percentage of Predisability Income specified in the Partial Disability Benefit section. Benefit payments will be subject to all other terms of the Policy that applied to the prior Disability.

This Recurrent Disability provision will cease to apply when you become eligible for coverage under any other group short-term disability policy.

EXCLUSIONS. Weekly Benefits will not be payable for any period of Disability:

(1) which is the result of an intentionally self-inflicted Injury or suicide attempt;
(2) during which you are not under the Regular Care of a Physician;
(3) which is the result of war (declared or undeclared) or any act of war;
(4) which is the result of a Sickness or Injury for which you receive benefits under Workers' Compensation or similar coverage;
(5) which arises out of (or in the course of) any employment for wage or profit, when the Disability would be covered by Workers' Compensation or similar coverage if:
   (a) the Employer had enrolled you for such coverage; and
   (b) you and your Employer had cooperated in filing a claim under that plan; or
(6) during which you receive payment under the Employer's Sick Leave or Salary Continuance Plan.

PRE-EXISTING CONDITION LIMITATION. The Policy will not cover any period of Disability:

(1) which is caused or contributed to by, or results from a Pre-Existing Condition; and
(2) which begins in the first 12 months after your Effective Date, unless you received no Treatment of the condition for 12 months in a row after your Effective Date.

"Pre-Existing Condition" means a Sickness or Injury for which you received Treatment within 3 months prior to your Effective Date.

"Treatment" means consultation, care and services by a Physician. It includes diagnostic measures and the prescription, refill and taking of prescribed drugs or medicines.

GENERAL PURPOSES AND LIMITATIONS OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION K.S.A.40-3001 et. seq.

DISCLAIMER

THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MAY NOT PROVIDE COVERAGE FOR ALL OR A PORTION OF THIS POLICY. IF COVERAGE IS PROVIDED, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS AND EXCLUSIONS, AND IS CONDITIONED UPON RESIDENCY IN THIS STATE. THEREFORE, YOU SHOULD NOT RELY UPON COVERAGE BY THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELECTING AN INSURANCE COMPANY OR IN SELECTING AN INSURANCE POLICY. INSURANCE COMPANIES AND THEIR AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELLING YOU ANY FORM OF AN INSURANCE POLICY, OR TO INDUCE YOU TO PURCHASE ANY FORM OF AN INSURANCE POLICY. EITHER THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE KANSAS INSURANCE DEPARTMENT WILL RESPOND TO ANY QUESTIONS YOU HAVE REGARDING THIS DOCUMENT.

Kansas Life and Health Insurance
Guaranty Association
2909 SW Maupin Lane
Topeka, KS 66614

Kansas Insurance Department
420 SW 9th Street
Topeka, KS 66612

This is a brief summary of the Kansas Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. If there is any inconsistency between this notice and Kansas law, then Kansas law will control.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Kansas law, with funding from assessments paid by other insurance companies. This safety net was created under Kansas law, which determines who and what is covered and the amounts of coverage. The basic protections provided by the Association are:

- Life Insurance

  $300,000 in death benefits

  $100,000 in cash surrender or withdrawal values

- Health Insurance

  $500,000 in hospital, medical and surgical insurance benefits

  $300,000 in disability insurance benefits

  $300,000 in long-term care insurance benefits

  $100,000 in other types of health insurance benefits

- Annuities

  $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits, as well as certain aggregate limits.

CERTIFICATE AMENDMENT

TO BE ATTACHED TO THE CERTIFICATE FOR GROUP POLICY NO.: 000010147074

ISSUED TO: USD 262 Valley Center Schools

Your Certificate is amended by adding the following provisions.

PRIOR INSURANCE CREDIT UPON TRANSFER OF
DISABILITY INCOME INSURANCE CARRIERS

This provision prevents loss of disability income coverage for you, which could otherwise occur solely because of a transfer of insurance carriers. The Policy will provide the following Prior Insurance Credit, when it replaces a prior plan.

"Prior Plan" means a prior carrier's group disability income policy, which the Policy replaced within 1 day of the prior plan's termination date.

FAILURE TO SATISFY ACTIVE WORK RULE. Subject to premium payments, the Policy will provide disability income coverage if you:

(1) were insured by the prior plan on its termination date; and
(2) were otherwise eligible under the Policy; but were not Actively-At-Work due to Injury or Sickness on its Effective Date.

AMOUNT OF COVERAGE. Until you satisfy the Policy's Active Work rule, your disability income coverage will not exceed that provided by the prior plan, had it remained in force. The Company will pay:

(1) the benefit the prior plan would have paid; minus
(2) any amount for which the prior carrier is liable.

DISABILITY DUE TO A PRE-EXISTING CONDITION. Benefits may be payable for a period of disability due to a Pre-Existing Condition if you:

(1) were insured by the prior plan on its termination date; and
(2) were Actively-At-Work and became insured under the Policy on its Effective Date.

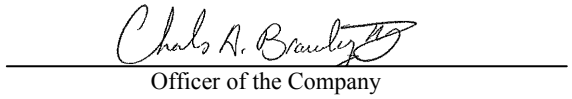
The benefits will be determined as follows:

A. The Company will apply the Policy's Pre-Existing Condition Limitation. If you qualify for benefits, you will be paid according to the Policy's benefit schedule.

B. If you cannot satisfy the Policy's Pre-Existing Condition Limitation; then the prior plan's pre-existing condition limitation will be applied, as follows:
   (1) If you satisfy the prior plan's pre-existing condition limitation, giving consideration towards continuous time insured under both policies; then benefits will be paid according to the prior plan's benefit schedule.
   (2) If you cannot satisfy the Pre-Existing Condition Limitation of the Policy, or that of the prior plan; then no benefit will be paid.

This Amendment takes effect on your effective date of coverage under the Policy. In all other respects, your Certificate remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

Lincoln Financial Group®

LINCOLN FINANCIAL GROUP® PRIVACY PRACTICES NOTICE

The Lincoln Financial Group companies* are committed to protecting your privacy. To provide the products and services you expect from a financial services leader, we must collect personal information about you. **We do not sell your personal information to third parties.** We share your personal information with third parties as necessary to provide you with the products or services you request and to administer your business with us. This Notice describes our current privacy practices. While your relationship with us continues, we will update and send our Privacy Practices Notice as required by law. Even after that relationship ends, we will continue to protect your personal information. **You do not need to take any action because of this Notice, but you do have certain rights as described below.**

INFORMATION WE MAY COLLECT AND USE

We collect personal information about you to help us identify you as our customer or our former customer; to process your requests and transactions; to offer investment or insurance services to you; to pay your claim; or to tell you about our products or services we believe you may want and use. The type of personal information we collect depends on the products or services you request and may include the following:

- **Information from you**: When you submit your application or other forms, you give us information such as your name, address, Social Security number; and your financial, health, and employment history.

- **Information about your transactions**: We keep information about your transactions with us, such as the products you buy from us; the amount you paid for those products; your account balances; and your payment history.

- **Information from outside our family of companies**: If you are purchasing insurance products, we may collect information from consumer reporting agencies such as your credit history; credit scores; and driving and employment records. With your authorization, we may also collect information, such as medical information from other individuals or businesses.

- **Information from your employer**: If your employer purchases group products from us, we may obtain information about you from your employer in order to enroll you in the plan.

HOW WE USE YOUR PERSONAL INFORMATION

We may share your personal information within our companies and with certain service providers. They use this information to process transactions you have requested; provide customer service; and inform you of products or services we offer that you may find useful. Our service providers may or may not be affiliated with us. They include financial service providers (for example, third party administrators; broker-dealers; insurance agents and brokers, registered representatives; reinsurers and other financial services companies with whom we have joint marketing agreements). Our service providers also include non-financial companies and individuals (for example, consultants; vendors; and companies that perform marketing services on our behalf). Information we obtain from a report prepared by a service provider may be kept by the service provider and shared with other persons; however, we require our service providers to protect your personal information and to use or disclose it only for the work they are performing for us, or as permitted by law.

When you apply for one of our products, we may share information about your application with credit bureaus. We also may provide information to group policy owners, regulatory authorities and law enforcement officials and to others when we believe in good faith that the law requires disclosure. In the event of a sale of all or part of our businesses, we may share customer information as part of the sale. **We do not sell or share your information with outside marketers who may want to offer you their own products and services; nor do we share information we receive about you from a consumer reporting agency. You do not need to take any action for this benefit.**

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

SECURITY OF INFORMATION

We have an important responsibility to keep your information safe. We use safeguards to protect your information from unauthorized disclosure. Our employees are authorized to access your information only when they need it to provide you with products, services, or to maintain your accounts. Employees who have access to your personal information are required to keep it confidential. Employees are trained on the importance of data privacy.

Questions about your personal information should be directed to:

Lincoln Financial Group
Attn: Enterprise Compliance and Ethics
Corporate Privacy Office, 7C-01
1300 S. Clinton St.
Fort Wayne, IN 46802

Please include all policy/contract/account numbers with your correspondence.

*This information applies to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company
Lincoln Financial Group Trust Company, LLC
Lincoln Financial Investment Services Corporation
Lincoln Investment Advisors Corporation
Lincoln Life & Annuity Company of New York
Lincoln Retirement Services Company, LLC
Lincoln Variable Insurance Products Trust
The Lincoln National Life Insurance Company

ADDITIONAL PRIVACY INFORMATION FOR INSURANCE PRODUCT CUSTOMERS

CONFIDENTIALITY OF MEDICAL INFORMATION

We understand that you may be especially concerned about the privacy of your medical information. We do not sell or rent your medical information to anyone; nor do we share it with others for marketing purposes. We only use and share your medical information for the purpose of underwriting insurance, administering your policy or claim and other purposes permitted by law, such as disclosure to regulatory authorities or in response to a legal proceeding.

MAKING SURE MEDICAL INFORMATION IS ACCURATE

We want to make sure we have accurate information about you. Upon written request we will tell you, within 30 business days, what personal information we have about you. You may see a copy of your personal information in person or receive a copy by mail, whichever you prefer. We will share with you who provided the information. In some cases we may provide your medical information to your personal physician. We will not provide you with information we have collected in connection with, or in anticipation of, a claim or legal proceeding. If you believe that any of our records are not correct, you may write and tell us of any changes you believe should be made. We will respond to your request within 30 business days. A copy of your request will be kept on file with your personal information so anyone reviewing your information in the future will be aware of your request. If we make changes to your records as a result of your request, we will notify you in writing and we will send the updated information, at your request, to any person who may have received the information within the prior two years. We will also send the updated information to any insurance support organization that gave us the information, and any service provider that received the information within the prior 7 years.

Questions about your personal medical information should be directed to:

Lincoln Financial Group
Attn: Medical Underwriting
P.O. Box 21008
Greensboro, NC 27420-1008

The CONFIDENTIALITY OF MEDICAL INFORMATION and MAKING SURE INFORMATION IS ACCURATE sections of this Notice apply to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company
Lincoln Life & Annuity Company of New York
The Lincoln National Life Insurance Company

APPENDIX I
ALLSTATE AFTER-TAX PLAN

This Appendix I contains the terms and conditions specific to the USD #262 Valley Center Allstate After-Tax Plan that may be elected under Section 4.02 of the Plan. Unless otherwise altered by the terms of this Appendix I, the terms and conditions of the Plan are incorporated into, and made applicable to, this Allstate After-Tax Plan.

Section I1.01 Eligibility/Plan Entry Dates. The eligibility conditions are the same as for the Plan. The Allstate After-Tax Plan entry date is the April 1 following date of hire.

Section I1.02 Benefits Provided under Individual Policies or Group Contracts. Under the Allstate After-Tax Plan, the Participant may choose to receive benefits in one or more of the following policies of insurance:

(a) *Accident Plan.* Benefits under this Accident Plan are identical to those described in, and shall be paid pursuant to the terms of, the individual policy of insurance or group contract, as applicable, issued by Allstate to the Participant. The provisions of that policy, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by Allstate.

(b) *Critical Illness Plan.* Benefits under the Critical Illness Plan are identical to those described in, and shall be paid pursuant to the terms of, the individual policy of insurance or group contract, as applicable, issued by Allstate to the Participant. The provisions of that policy, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by Allstate.

(c) *Cancer Plan.* Benefits under the Cancer Plan are identical to those described in, and shall be paid pursuant to the terms of, the individual policy of insurance or group contract, as applicable, issued by Allstate to the Participant. The provisions of that policy, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by Allstate.

Section I1.03 Obligation to Pay Benefits. The Employer makes no promise and shall have no obligation to provide or pay benefits under these individual policies or group contracts, as applicable, from its own assets. The rights and conditions with respect to the benefits payable under this Allstate After-Tax Plan shall be determined from each Allstate policy. The Participant shall bear fully any and all risk of Allstate's insolvency.

Section I1.04 Cost of Coverage. The Participant's monthly premiums are determined by Allstate pursuant to the terms of the policy or policies issued by Allstate to the Participant. Under the terms of those policies, Allstate may have the right to change the amount of the applicable premium from time to time. The Participant must pay the entire cost of the monthly premium for coverage on an after-tax basis.

Section I1.05 Election to Participate. A Participant who desires to receive benefits under this Allstate After-Tax Plan must elect to participate in this Allstate After-Tax Plan and must make arrangements to pay his/her share of the applicable premium. If a Participant does not elect to participate, the Employer will not provide him/her with any benefits under this Plan.

Section I1.06 Payment of Premium. A Participant who has elected to participate in this Allstate After-Tax Plan must pay the applicable premium on an after-tax basis by authorizing a payroll deduction in the amount of the applicable premium.

Section I1.07 Claims Administration. Allstate will act as Claims Administrator with respect to any Claim for benefits listed in Section I1.02 above under this Allstate After-Tax Plan. Allstate has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit Claims, in accordance with the terms of the individual policies or group contracts, as applicable. Except as otherwise provided by law, all decisions of the Claims Administrator shall be final and binding.

Section I1.08 Termination of Participation. A Participant ceases to be a Participant as of the earliest of the following:

(a) The last effective date of coverage – as specified by the individual policies or group contract – following the Participant's termination of employment with the Employer;

(b) The date on which the Participant's election to participate expires;

(c) The end of a period for which a required contribution by the Participant was last paid, taking into account any grace periods required by law;

(d) The last effective date of coverage – as specified by the individual policies or group contract – following the date on which the Participant ceases to be an Eligible Employee; or

(e) The date on which this Allstate After-Tax Plan terminates.

[The remainder of this page is intentionally left blank.]

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

GROUP ACCIDENT INSURANCE POLICY
INCLUDES ACCIDENTAL DEATH AND DISMEMBERMENT
NON-PARTICIPATING

American Heritage Life Insurance Company (referred to as we, us, or our) will provide benefits under this policy. We make this promise subject to all of the provisions of this policy.

The policyholder should read this group policy carefully and contact us promptly with any questions. This group policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA), and consists of:

1. all policy provisions and any amendments and/or attachments issued; and
2. the policyholders' signed application.

This policy may be changed in whole or in part. The approval must be in writing, signed by one of our executive officers and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida on the policy effective date.

Secretary

President

THIS IS A GROUP ACCIDENT ONLY POLICY WHICH PROVIDES BENEFITS FOR OFF THE JOB ACCIDENTS AS DEFINED WITHIN THIS POLICY OR OTHER BENEFITS THAT MAY BE ADDED. THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.

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POLICY SPECIFICATIONS

POLICYHOLDER:	USD 262 VALLEY CENTER SCHOOL DISTRICT
POLICY NUMBER:	20216
POLICY EFFECTIVE DATE:	April 1, 2014
POLICY ANNIVERSARY DATE:	April 1, 2015 and the first day of April each calendar year thereafter.
GOVERNING JURISDICTION:	the state of Kansas and subject to the laws of that jurisdiction.

ELIGIBLE CLASS(ES): All Classified and Certified Employees working 20 or more hours per week excluding those who are insured under any other accident policy issued by American Heritage Life Insurance Company

ELIGIBILITY WAITING PERIOD: No Wait

PLAN I BENEFITS: See page 3A
Benefit Enhancements (2.00 units) – See page 3B

INITIAL RATE: Monthly rate of $11.28 per insured employee for Individual Coverage; or
$16.92 per insured employee for Individual and Spouse Coverage; or
$22.56 per insured employee for Individual and Child(ren) Coverage; or
$28.20 per insured employee for Family Coverage

PLAN II BENEFITS: See page 3A
Benefit Enhancements (3.00 units) – See page 3B

INITIAL RATE: Monthly rate of $16.92 per insured employee for Individual Coverage; or
$25.38 per insured employee for Individual and Spouse Coverage; or
$33.84 per insured employee for Individual and Child(ren) Coverage; or
$42.30 per insured employee for Family Coverage

RATE GUARANTEE DATE: April 1, 2016

PREMIUM DUE: The initial date agreed to between American Heritage Life Insurance Company and the Policyholder and each specified date thereafter.

All premiums must be sent to us on or before the premium due date. The premium must be paid in United States dollars.

COST OF COVERAGE: The insured employee pays the cost of coverage**.**

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES:
These are the policyholder's divisions, subsidiaries, or affiliates listed below. The policyholder may act for and on behalf of any and all of these in all matters that pertain to this policy. Every act done by, agreement made with, or notice given to the policyholder will be binding on them.

Name	**Location (City and State)**
None	

ACCIDENT POLICY
SEE BENEFITS SECTION OF CERTIFICATE FOR DETAILS OF BENEFITS
SEE PAGE 3A OF CERTIFICATE FOR BENEFIT AMOUNTS

PLAN I BENEFITS		**AMOUNT**		
		INSURED EMPLOYEE	SPOUSE	CHILD(REN)
1. ACCIDENTAL DEATH	Principal Amount	$40,000	$20,000	$10,000
2. COMMON CARRIER ACCIDENTAL DEATH	Principal Amount	$200,000	$100,000	$50,000
3. DISMEMBERMENT	Principal Amount	$40,000*	$20,000*	$10,000*
4. DISLOCATION/FRACTURE	Principal Amount	$4,000*	$2,000*	$1,000*
5. HOSPITALIZATION CONFINEMENT	Principal Amount	$1,000	$1,000	$1,000
6. DAILY HOSPITALIZATION CONFINEMENT	Daily Benefit	$200	$200	$200
7. INTENSIVE CARE	Daily Benefit	$400	$400	$400
8. AMBULANCE SERVICES				
A. GROUND AMBULANCE		$200	$200	$200
B. AIR AMBULANCE		$600	$600	$600
9. ACCIDENT PHYSICIAN TREATMENT		$100	$100	$100
10. X-RAY		$200	$200	$200
11. EMERGENCY ROOM SERVICES		$200	$200	$200

*** MULTIPLIED BY THE APPLICABLE FACTOR LISTED IN THE SCHEDULE OF BENEFITS AND FACTORS IN THE CERTIFICATE.**

PLAN II BENEFITS		**AMOUNT**		
		INSURED EMPLOYEE	SPOUSE	CHILD(REN)
1. ACCIDENTAL DEATH	Principal Amount	$40,000	$20,000	$10,000
2. COMMON CARRIER ACCIDENTAL DEATH	Principal Amount	$200,000	$100,000	$50,000
3. DISMEMBERMENT	Principal Amount	$40,000*	$20,000*	$10,000*
4. DISLOCATION/FRACTURE	Principal Amount	$4,000*	$2,000*	$1,000*
5. HOSPITALIZATION CONFINEMENT	Principal Amount	$1,000	$1,000	$1,000
6. DAILY HOSPITALIZATION CONFINEMENT	Daily Benefit	$200	$200	$200
7. INTENSIVE CARE	Daily Benefit	$400	$400	$400
8. AMBULANCE SERVICES				
A. GROUND AMBULANCE		$200	$200	$200
B. AIR AMBULANCE		$600	$600	$600
9. ACCIDENT PHYSICIAN TREATMENT		$100	$100	$100
10. X-RAY		$200	$200	$200
11. EMERGENCY ROOM SERVICES		$200	$200	$200

*** MULTIPLIED BY THE APPLICABLE FACTOR LISTED IN THE SCHEDULE OF BENEFITS AND FACTORS IN THE CERTIFICATE.**

ACCIDENT POLICY
GROUP ACCIDENT BENEFIT ENHANCEMENTS
SEE BENEFITS SECTION OF CERTIFICATE FOR DETAILS OF BENEFITS
SEE PAGE 3A OF CERTIFICATE FOR BENEFIT AMOUNTS

	PLAN I BENEFITS		AMOUNT
1.	LACERATIONS		$100
2.	BURNS		
	A. SECOND AND THIRD DEGREE BURNS COVERING LESS THAN 15% OF THE TOTAL BODY SURFACE		$200
	B. SECOND AND THIRD DEGREE BURNS COVERING 15% OR MORE OF THE TOTAL BODY SURFACE		$1,000
3.	SKIN GRAFT		50% OF BURN BENEFIT
4.	BRAIN INJURY DIAGNOSIS		$300
5.	COMPUTED TOMOGRAPHY SCAN OR MAGNETIC RESONANCE IMAGING		$100
6.	PARALYSIS		
	A. PARAPLEGIA (PARALYSIS OF 2 OR 3 LIMBS)		$15,000
	B. QUADRIPLEGIA (PARALYSIS OF 4 LIMBS)		$30,000
7.	COMA WITH RESPIRATORY ASSISTANCE		$20,000
8.	OPEN ABDOMINAL OR THORACIC SURGERY		$2,000
9.	TENDON, LIGAMENT, ROTATOR CUFF OR KNEE CARTILAGE SURGERY		
	A. WITH REPAIR		$1,000
	B. WITHOUT REPAIR		$300
10.	RUPTURED DISC SURGERY		$1,000
11.	EYE SURGERY		$200
12.	GENERAL ANESTHESIA		$200
13.	BLOOD AND PLASMA		$600
14.	APPLIANCE		$250
15.	MEDICAL SUPPLIES		$10
16.	MEDICINE		$10
17.	PROSTHESIS		
	A. 1 DEVICE		$1,000
	B. 2 OR MORE DEVICES		$2,000
18.	PHYSICAL THERAPY	Daily Benefit	$60
19.	REHABILITATION UNIT	Daily Benefit	$200
20.	NON-LOCAL TRANSPORTATION	Per Trip	$800
21.	FAMILY MEMBER LODGING	Daily Benefit	$200
22.	POST-ACCIDENT TRANSPORTATION		$400
23.	ACCIDENT FOLLOW-UP TREATMENT	Daily Benefit	$100

ACCIDENT POLICY
GROUP ACCIDENT BENEFIT ENHANCEMENTS
SEE BENEFITS SECTION OF CERTIFICATE FOR DETAILS OF BENEFITS
SEE PAGE 3A OF CERTIFICATE FOR BENEFIT AMOUNTS (CONTINUED)

	PLAN II BENEFITS		AMOUNT
1.	LACERATIONS		$150
2.	BURNS		
	A. SECOND AND THIRD DEGREE BURNS COVERING LESS THAN 15% OF THE TOTAL BODY SURFACE		$300
	B. SECOND AND THIRD DEGREE BURNS COVERING 15% OR MORE OF THE TOTAL BODY SURFACE		$1,500
3.	SKIN GRAFT		50% OF BURN BENEFIT
4.	BRAIN INJURY DIAGNOSIS		$450
5.	COMPUTED TOMOGRAPHY SCAN OR MAGNETIC RESONANCE IMAGING		$150
6.	PARALYSIS		
	A. PARAPLEGIA (PARALYSIS OF 2 OR 3 LIMBS)		$22,500
	B. QUADRIPLEGIA (PARALYSIS OF 4 LIMBS)		$45,000
7.	COMA WITH RESPIRATORY ASSISTANCE		$30,000
8.	OPEN ABDOMINAL OR THORACIC SURGERY		$3,000
9.	TENDON, LIGAMENT, ROTATOR CUFF OR KNEE CARTILAGE SURGERY		
	A. WITH REPAIR		$1,500
	B. WITHOUT REPAIR		$450
10.	RUPTURED DISC SURGERY		$1,500
11.	EYE SURGERY		$300
12.	GENERAL ANESTHESIA		$300
13.	BLOOD AND PLASMA		$900
14.	APPLIANCE		$375
15.	MEDICAL SUPPLIES		$15
16.	MEDICINE		$15
17.	PROSTHESIS		
	A. 1 DEVICE		$1,500
	B. 2 OR MORE DEVICES		$3,000
18.	PHYSICAL THERAPY	Daily Benefit	$90
19.	REHABILITATION UNIT	Daily Benefit	$300
20.	NON-LOCAL TRANSPORTATION	Per Trip	$1,200
21.	FAMILY MEMBER LODGING	Daily Benefit	$300
22.	POST-ACCIDENT TRANSPORTATION		$600
23.	ACCIDENT FOLLOW-UP TREATMENT	Daily Benefit	$150

POLICYHOLDER PROVISIONS

RATE GUARANTEE

A change in premium rate will not take effect before the Rate Guarantee Date except for reasons which affect the risk assumed, including those reasons shown below:

1. a change occurs in this plan design; or
2. a division, subsidiary, or affiliated company is added or deleted; or
3. the number of insured employees or members changes by 20% or more; or
4. a new law or a change in any existing law is enacted which applies to this plan; or
5. less than 5 of those eligible for coverage are participating.

We will notify the policyholder in writing at least 30 days before a premium rate is changed. A change may take effect on an earlier date when both we and the policyholder agree in writing.

PREMIUM INCREASES OR DECREASES

Premium increases or decreases may take effect any time subject to the Rate Guarantee provision. If they take effect during a policy month, they are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

INFORMATION REQUIRED FROM THE POLICYHOLDER

The policyholder must provide us with the following on a regular basis:

1. information about employees or members:
    a. who are eligible to become insured; and
    b. whose coverage changes; and
    c. whose coverage ends; and
2. any information that may be required to manage a claim; and
3. any other information that may be reasonably required.

Policyholder records that have a bearing, in our opinion, on this policy will be available for review by us at any reasonable time.

INCONTESTABILITY

After 2 years from the effective date of this policy, no misstatement of the policyholder, made in any applications, can be used to void this policy.

CLERICAL ERROR

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by the policyholder documenting any clerical errors.

POLICYHOLDER PROVISIONS (Continued)

CANCELING POLICY

This policy can be canceled:
1. by us; or
2. by the policyholder.

We may cancel or offer to modify this policy, with at least 31 days written notice to the policyholder, if:
1. less than 5 of those eligible for coverage are participating; or
2. this policy has been in effect more than 12 months; or
3. the policyholder does not promptly provide us with information that is reasonably required; or
4. the policyholder fails to perform any of its obligations that relate to this policy; or
5. fewer than 5 employees or members are insured; or
6. premiums are not received within the 31 day grace period.

If the premiums are not received during the grace period, this policy will terminate automatically at the end of the grace period. Premiums are required for coverage during the grace period. All premiums due must be paid to us for the full period this policy is in force.

The policyholder may cancel this policy by written notice delivered to us at least 31 days prior to the cancellation date. When both the policyholder and we agree, this policy can be canceled on an earlier date. If canceled, coverage will end at 12:00 midnight on the last day of coverage.

If this policy is canceled, the cancellation will not affect a payable claim incurred prior to cancellation.

ENTIRE CONTRACT

The contract consists of the following items:
1. the group policy; and
2. any amendments and endorsements; and
3. the applications and other written statements of the policyholder; and
4. any individual applications, enrollments, evidence of insurability or other statements of the insured employee or member.

Any statements made by the policyholder or by a covered person, in the absence of fraud, are representations and not warranties. Only written statements signed by the policyholder or a covered person will be used in defense of a claim. A copy of any written statement, if applicable, will be furnished to the policyholder or the covered person or his or her personal representative, if any, if such written statement will be used in defense of a claim.

CERTIFICATES OF INSURANCE

We will furnish to the policyholder a certificate of insurance for delivery to each insured employee or member. The certificate will provide a description of the insurance provided by this policy and will state:
1. the essential features of the insurance coverage; and
2. to whom benefits are payable.

If there is any discrepancy between the provisions of any certificate and the provisions of this policy, the provisions of this policy govern.

GLOSSARY

Active Employment means the employee or member is working for the employer for earnings that are paid regularly and that he or she is performing the material and substantial duties of his or her regular occupation. For the purposes of this policy:

1. the employee or member must be working at least the minimum number of hours as described under Eligible Class(es); and
2. the employee or member will be deemed to be in active employment on a day which is not the employer's scheduled work days only if he or she was actively employed on the preceding scheduled work day.

The employee's or member's work site must be:

1. the employer's usual place of business; or
2. an alternative work site at the direction of the employer; or
3. a location to which the job requires such employee or member to travel.

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. Temporary and seasonal workers are excluded from coverage.

Calendar Year means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

Covered Person means any of the following:

1. any eligible family member (including the employee or member) named on the enrollment or evidence of insurability and acceptable for coverage by us; or
2. any eligible family member added by endorsement after the effective date; or
3. a newborn child.

Eligibility Waiting Period means the continuous period of time that the employee or member must be in active employment in an eligible class before he or she is eligible for coverage.

Employee means a person who is: (a) a citizen or resident of the United States or one of its territories; and (b) in active employment with the employer or is a member in good standing in the labor union, association or other entity named as the policyholder.

Employer means the individual, company or corporation where the employee or member is in active employment, and includes any division, subsidiary, or affiliated company of named in this policy.

Family Coverage means coverage that includes the insured employee or member as defined, his or her eligible spouse or Domestic Partner and children as described in the certificate.

Grace Period means a period of 31 days following the premium due date during which premium payment may be made.

Individual and Child(ren) Coverage means coverage that includes only the insured employee or member, as defined and eligible children as described in the certificate.

Individual and Spouse Coverage means coverage that includes only the insured employee or member, as defined, and his or her eligible spouse or Domestic Partner as described in the certificate.

Individual Coverage means coverage that includes only the insured employee or member, as defined.

Initial Enrollment Period means one of the following periods during which the employee or member may first apply in writing for coverage under this policy:

1. if the employee or member is eligible for coverage on the policy effective date, a period before the policy effective date as set by us and the policyholder; or
2. if the employee or member becomes eligible for coverage after the policy effective date, the period ending 31 days after the date he or she is first eligible to apply for coverage.

GLOSSARY (Continued)

Insured Employee or Member means the employee or member accepted for coverage by us who has completed and signed the enrollment form or evidence of insurability and whose name appears on the certificate specification page.

Member means a member in good standing in an labor union, association or other entity named as the policyholder and who is: (a) a citizen or resident of the United States; and (b) is (1) engaged in, or (2) able to engage in and currently seeking, active employment.

Plan means a line of coverage under the policy.

Policyholder means the legal entity to whom this policy is issued.

We, Us and **Our** means American Heritage Life Insurance Company.

CERTIFICATE PROVISIONS MADE PART OF THIS GROUP POLICY

The remainder of this group policy consists of the provisions that will appear in the group certificate, including any endorsements or amendments. The group certificate describes the insurance made available under this group policy to insured employees or members and their dependents, if applicable.

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AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

THIS IS A GROUP ACCIDENT ONLY POLICY WHICH PROVIDES BENEFITS FOR OFF THE JOB ACCIDENTS AS DEFINED WITHIN THIS POLICY OR OTHER BENEFITS THAT MAY BE ADDED. THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.

AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
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JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

CERTIFICATE OF INSURANCE

This certificate of insurance ("certificate") describes your insurance coverage under the policy.

In this certificate, the words:

"You" and "your" mean the named insured employee or member shown on page 3 who is a member of an eligible class as described in the policy and for whom premiums are remitted.

"We", "us" and "our" mean American Heritage Life Insurance Company.

"This policy" and "the policy" mean the policy of insurance issued by us to the policyholder.

The policy alone makes up the agreement under which insurance coverage is provided and benefits are determined. If the terms of your certificate and the policy differ, the policy will govern. The policy may be inspected at the office of the policyholder during normal business hours.

Coverage under the policy is issued in consideration of your enrollment or other form of application and the payment of the first premium.

We certify that coverage under the policy is in effect for persons who have satisfied all eligibility requirements and for whom the required premium has been paid when due.

The policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

The policy and this certificate may be changed in whole or in part or cancelled by agreement between us and the policyholder. Such an action may be taken without the consent or notice to you or anyone covered under the policy. Only an authorized officer at our home office can approve a change. The approval must be in writing and endorsed on or attached to the policy. No other person, including an agent, may change the policy or certificate or waive any of its provisions. Premiums are subject to periodic changes.

This certificate supersedes and replaces any certificate previously issued to you under the policy.

Secretary

President

THIS IS GROUP ACCIDENT ONLY COVERAGE WHICH PROVIDES BENEFITS FOR OFF THE JOB ACCIDENTS AS DEFINED WITHIN THIS CERTIFICATE OR OTHER BENEFITS THAT MAY BE ADDED. THIS COVERAGE DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.

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AMERICAN HERITAGE LIFE INSURANCE COMPANY
1776 American Heritage Life Drive, Jacksonville, Florida 32224

CERTIFICATE SPECIFICATIONS

FORM NO.	DESCRIPTION OF BENEFITS	NUMBER OF YEARS PAYABLE*
GVAC2KS	ACCIDENT COVERAGE (2.00 UNIT(S)) *** SEE PAGE 3A FOR BENEFIT AMOUNTS ***	LIFE
	BENEFIT ENHANCEMENTS (2.00 UNIT(S)) *** SEE PAGE 3B FOR BENEFIT AMOUNTS ***	LIFE

***** SUBJECT TO TERMINATION OF COVERAGE PROVISION

FAMILY COVERAGE

BILLABLE PREMIUM $XX.XX

PREMIUM PAYMENT METHOD PAYROLL MONTHLY

INSURED:	JOHN DOE	ISSUE AGE:	35
EFFECTIVE DATE:	APRIL 01, 2012	CERTIFICATE NUMBER:	123456
GROUP POLICY NUMBER:	20216		
BENEFICIARY:	AS NAMED ON ENROLLMENT FORM		

ACCIDENT COVERAGE

ACCIDENT CERTIFICATE
SEE BENEFITS SECTION OF CERTIFICATE FOR DETAILS OF BENEFITS

	BENEFITS		AMOUNT		
			INSURED EMPLOYEE	SPOUSE	CHILD(REN)
1.	ACCIDENTAL DEATH	Principal Amount	$60,000	$30,000	$15,000
2.	COMMON CARRIER ACCIDENTAL DEATH	Principal Amount	$300,000	$150,000	$75,000
3.	DISMEMBERMENT	Principal Amount	$60,000*	$30,000*	$15,000*
4.	DISLOCATION/FRACTURE	Principal Amount	$6,000*	$3,000*	$1,500*
5.	HOSPITALIZATION CONFINEMENT	Principal Amount	$1,500	$1,500	$1,500
6.	DAILY HOSPITALIZATION CONFINEMENT	Daily Benefit	$300	$300	$300
7.	INTENSIVE CARE	Daily Benefit	$600	$600	$600
8.	AMBULANCE SERVICES				
	A. GROUND AMBULANCE		$300	$300	$300
	B. AIR AMBULANCE		$900	$900	$900
9.	ACCIDENT PHYSICIAN TREATMENT		$150	$150	$150
10.	X-RAY		$300	$300	$300
11.	EMERGENCY ROOM SERVICES		$300	$300	$300

*** MULTIPLIED BY THE APPLICABLE FACTOR LISTED IN THE SCHEDULE OF BENEFITS AND FACTORS.**

ACCIDENT CERTIFICATE
GROUP ACCIDENT BENEFIT ENHANCEMENTS
SEE BENEFITS SECTION OF CERTIFICATE FOR DETAILS OF BENEFITS

	BENEFITS		AMOUNT
1.	LACERATIONS		$150
2.	BURNS		
	A. SECOND AND THIRD DEGREE BURNS COVERING LESS THAN 15% OF THE TOTAL BODY SURFACE		$300
	B. SECOND AND THIRD DEGREE BURNS COVERING 15% OR MORE OF THE TOTAL BODY SURFACE		$1,500
3.	SKIN GRAFT	50% OF BURN BENEFIT	
4.	BRAIN INJURY DIAGNOSIS		$450
5.	COMPUTED TOMOGRAPHY SCAN OR MAGNETIC RESONANCE IMAGING		$150
6.	PARALYSIS		
	A. PARAPLEGIA (PARALYSIS OF 2 OR 3 LIMBS)		$22,500
	B. QUADRIPLEGIA (PARALYSIS OF 4 LIMBS)		$45,000
7.	COMA WITH RESPIRATORY ASSISTANCE		$30,000
8.	OPEN ABDOMINAL OR THORACIC SURGERY		$3,000
9.	TENDON, LIGAMENT, ROTATOR CUFF OR KNEE CARTILAGE SURGERY		
	A. WITH REPAIR		$1,500
	B. WITHOUT REPAIR		$450
10.	RUPTURED DISC SURGERY		$1,500
11.	EYE SURGERY		$300
12.	GENERAL ANESTHESIA		$300
13.	BLOOD AND PLASMA		$900
14.	APPLIANCE		$375
15.	MEDICAL SUPPLIES		$15
16.	MEDICINE		$15
17.	PROSTHESIS		
	A. 1 DEVICE		$1,500
	B. 2 OR MORE DEVICES		$3,000
18.	PHYSICAL THERAPY	Daily Benefit	$90
19.	REHABILITATION UNIT	Daily Benefit	$300
20.	NON-LOCAL TRANSPORTATION	Per Trip	$1,200
21.	FAMILY MEMBER LODGING	Daily Benefit	$300
22.	POST-ACCIDENT TRANSPORTATION		$600
23.	ACCIDENT FOLLOW-UP TREATMENT	Daily Benefit	$150

GENERAL PROVISIONS

EFFECTIVE DATE OF COVERAGE

Your coverage will be effective at 12:01 a.m. on the effective date shown on page 3 provided you are actively employed on that date.

If you are not actively employed on that date due to disability, injury, sickness, temporary layoff, leave of absence or Family and Medical Leave of Absence, coverage begins on the date you return to active employment. This applies to your initial coverage, as well as any increase or addition to coverage that occurs after your initial coverage is effective.

For any change in coverage, the change in coverage is effective on the date we approve such change.

CERTIFICATE OF INSURANCE

This certificate of insurance provides a description of the insurance provided by the policy issued to the policyholder. It describes the essential features of the insurance coverage and to whom benefits are payable.

If there is any discrepancy between the provisions of this certificate and the provisions of the policy, the provisions of the policy govern.

WHEN YOU CAN ENROLL, CHANGE OR DISCONTINUE COVERAGE

1. You may apply for coverage during:
   a. the initial enrollment period; or
   b. at any other time.
2. You may increase coverage at any time.
3. You may decrease coverage at any time.
4. You may discontinue coverage at any time.

ELIGIBILITY OF DEPENDENTS

Eligible dependents are:
1. your legal spouse or domestic partner; and
2. your children and your domestic partner's children.

A child is a person under age 26 who is:
1. your or your domestic partner's natural or adopted son or daughter, stepson or stepdaughter; or
2. a foster child who is placed with you or your domestic partner by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

A child born to you or your spouse or domestic partner, will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for any other child insured under the certificate. No additional premium will be required for newborns added if you already have children coverage in force at the time the newborn is added.

If you do not already have children coverage in force, or do not have coverage in force that covers more than one child, newborn children are automatically covered from the moment of birth for a period of 31 days. If you desire uninterrupted coverage for a newborn child, you must notify the policyholder within 31 days of that child's birth. Upon notification to us, we will convert your coverage to include the additional child and provide notification of the additional premium due. If you do not notify the policyholder within 31 days of the birth of the child, the temporary automatic coverage ends.

If you marry and desire coverage for your spouse, you must notify the policyholder of the marriage within 31 days of the marriage. We will change your coverage to include your spouse and provide notification of the additional premium due.

ELIGIBILITY OF DEPENDENTS (Continued)

If you enter into a domestic partnership and desire coverage for your domestic partner, you must notify the policyholder of the domestic partnership within 31 days of the date the domestic partnership was formed. We will change your coverage to include your domestic partner and provide notification of the additional premium due.

An adopted child or child pending adoption will be covered as follows:
1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by you has been entered within 31 days after the date of birth.
2. If adoption proceedings have been instituted by you within 31 days after the date of birth and you have temporary custody, coverage is provided from the moment of birth.
3. Coverage shall begin from the moment of placement.

Coverage must be provided as long as you have custody of the child pursuant to decree of the court and required premiums are paid.

If you do not already have child coverage in force, or do not have coverage in force that covers more than one child, we will convert your coverage to include the additional adopted child or child pending adoption and provide notification of the additional premium due.

TERMINATION OF COVERAGE

Your coverage under the policy ends on the earliest of:
1. the date the policy is canceled; or
2. the last day of the period for which any required premium payments were made; or
3. the last day you are actively employed with your employer or a member in good standing in the labor union, association or other entity that is the policyholder, except as provided under the TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE provision; or
4. the date you are no longer in an eligible class; or
5. the date your class is no longer eligible; or
6. upon our discovery of fraud or material misrepresentation in the presentation of a claim under this certificate.

We will provide coverage for a payable claim that occurs while a covered person is covered under the policy.

If your spouse is a covered person, your spouse's coverage ends upon valid decree of divorce or your death.

If your domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or your death.

Coverage for your child will end on the issue day of the month that follows when the child: (a) reaches age 26; or (b) otherwise does not meet the requirements of an eligible dependent.

Coverage does not end for an incapacitated dependent child who:
1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and
3. is chiefly dependent upon you for support and maintenance.

Coverage for an incapacitated dependent child continues as long as the certificate remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished, in writing, to us when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as often as may be required, but no more often than annually after the 2 year period following the child's attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims will not be paid. There may be no refund due if you have coverage in force that covers more than one child and there are other eligible dependents still insured under the policy.

Coverage may be eligible for continuation as outlined in the CONTINUATION OF INSURANCE provision.

GENERAL PROVISIONS (Continued)

TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE

If you cease active employment or membership in the union or association because of a temporary layoff or leave of absence while coverage is in force, we will continue your coverage in accordance with the personnel practices of the policyholder, if premium payments continue and the policyholder approved your leave in writing. Coverage will be continued for 3 months following the date you ceased active employment or membership in the union or association.

If your coverage ends while on a Family and Medical Leave of Absence, your coverage will be reinstated when you return to active status.

LEGAL ACTION

No legal action may be brought to obtain benefits under the policy:
1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 5 years from the time written proof of loss is required to have been furnished.

INCONTESTABILITY

After 2 years from the effective date of coverage, no misstatement of a covered person, made in writing, can be used to void coverage or deny a claim.

CLERICAL ERROR

Clerical error on the part of the policyholder, by any employer or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by us or the policyholder or any employer documenting any clerical errors.

AGENCY

For purposes of the policy, the policyholder acts on its own behalf or as your agent. Under no circumstances will the policyholder be deemed the agent of American Heritage Life Insurance Company.

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EXCLUSIONS AND LIMITATIONS

We will not pay any benefits for any loss that is caused by, contributed to by or results from:

1. Injury incurred prior to the covered person's effective date of coverage subject to the incontestability provision.
2. An injury that occurred as a result of an on the job accident.
3. Any act of war whether or not declared, participation in a riot, insurrection or rebellion.
4. Suicide, or any attempt at suicide, whether sane or insane.
5. Intentionally self-inflicted injury or action.
6. Any injury sustained while the covered person is under the influence of alcohol or any narcotic, unless administered upon the advice of a physician.
7. Any bacterial infection (except pyogenic infections which shall occur with and through an accidental cut or wound).
8. Participation in any form of aeronautics except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports.
9. Engaging in an illegal occupation or committing or attempting to commit an assault or felony.
10. Driving in any organized or scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway.
11. Hernia, including complications due to hernia.

"Under the influence" means a condition as determined by the laws of the state in which the loss occurred.

Any injury incurred while a covered person is an active member of the Military; Naval; or Air Forces of any country or combination of countries is not covered. Upon notice and proof of service in such forces, we will return the pro-rata portion of the premium paid for any period of such service.

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BENEFIT INFORMATION

If, while this certificate is in force and as the result of an off the job accident, a covered person sustains an injury, which results, within 90 days (180 days for Accidental Death or Dismemberment) or unless otherwise stated from the date of a covered accident, in any of the losses stated in the BENEFIT INFORMATION provision, and is diagnosed by a physician, we pay the following benefits for such loss. Any loss not stated in the BENEFIT INFORMATION provision is not covered under this certificate. Treatment must be received in the United States or its territories.

1. **Accidental Death:** We pay a benefit equal to the principal amount stated on page 3A. Benefits are subject to all of the terms, conditions and provisions of the certificate.

2. **Common Carrier Accidental Death:** We pay a benefit equal to the principal amount stated on page 3A, if death results from an injury while riding as a fare paying passenger on a scheduled common carrier. Benefits are subject to all of the terms, conditions and provisions of the certificate.

3. **Dismemberment:** We pay a benefit equal to the principal amount stated on page 3A, multiplied by the applicable factor in the Schedule of Benefits and Factors. If more than one dismemberment is sustained in any one injury, the total amount we will pay for the multiple dismemberments will not exceed the dismemberment principal amount stated on page 3A. Benefits are subject to all of the terms, conditions and provisions of the certificate.

   Loss of hand or hands, or foot or feet, means total and permanent severance at or above the wrist or ankle joint. Loss of arm or arms or leg or legs, means severance at or above the elbow joint or knee joint. The loss of eye or eyes means the entire and irrecoverable loss of sight. The loss of finger means the severance through or above metacarpophalangeal joints.

4. **Dislocation or Fracture:** We pay a benefit equal to the principal amount stated on page 3A, multiplied by the applicable factor in the Schedule of Benefits and Factors. If more than one dislocation or fracture is sustained in any one injury, the total amount we will pay for the multiple dislocations or fractures will not exceed the dislocation or fracture principal amount stated on page 3A. No benefit will be paid for any dislocation or fracture that is not listed in the Schedule of Benefits and Factors.

5. **Hospitalization Confinement:** We pay the amount stated on page 3A the first time a covered person is hospital confined after that person's effective date of coverage as a result of an injury. This benefit is payable only once per covered person per calendar year.

6. **Daily Hospital Confinement:** We pay a daily benefit of the amount stated on page 3A if a covered person is confined in a hospital, as a result of an injury. This benefit is paid for each day of hospital confinement, up to a maximum of 90 days for any one injury, starting with the first full day of confinement. A day is a 24 hour period.

   "Hospital Confined or Confinement" means a confinement as an inpatient in a hospital for which a room and board charge is made by the hospital. It does not include confinement for an observation room or a fractional part of a day.

   "Inpatient" means a covered person who is a resident patient using the room and board facilities of a hospital.

7. **Intensive Care:** We pay a daily benefit of the amount stated on page 3A if a covered person is confined in a hospital intensive care unit, as a result of an injury. This benefit is paid for each day of intensive care unit confinement up to 90 days for each period of continuous hospital intensive care confinement. A day is a 24 hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit stated on page 3A is paid.

   "Continuous Hospital Intensive Care Unit Confinement" means one continuous confinement or two or more hospital intensive care unit confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

BENEFIT INFORMATION (Continued)

7. Intensive Care (Continued):

"Hospital Intensive Care Unit" means a hospital area of special care, which at the time of admission is separate and apart from the surgical recovery room, other rooms, beds, or wards normally used for patient confinement. In addition, the unit must provide the following:

a. 24 hour continuous nursing care attended by nurses assigned to the unit on a full time basis; and
b. direction and/or supervision by a full time physician director or a standing "intensive care" committee of the medical staff; and
c. special medical apparatus used to treat the critically ill.

"Nurse" means any one of the following who is not a member of the covered person's immediate family or employed by the hospital where the covered person is confined:

a. licensed practical nurse (L.P.N.); or
b. licensed vocational nurse (L.V.N.); or
c. graduate registered nurse (R.N.) ; or
d. advanced registered nurse practitioner.

8. Ambulance Services: We pay one of the amounts stated on page 3A depending on the method of transfer, if a covered person, as a result of an injury, requires ambulance service for the transfer to or from a hospital.

9. Accident Physician Treatment: We pay the benefit stated on page 3A if a covered person, as a result of an injury, receives treatment by a physician. This benefit is payable only once per covered person, per accident.

10. X-Ray: We pay the benefit stated on page 3A if a covered person, as a result of an injury, receives x-rays. This benefit is payable only once per covered person, per accident.

11. Emergency Room Services: We pay the benefit stated on page 3A if a covered person, as a result of an injury, receives emergency room services. This benefit is payable only once per covered person, per accident.

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BENEFIT INFORMATION (Continued)

BENEFIT ENHANCEMENTS

1. **Lacerations:** We pay the amount shown on page 3B if a covered person receives treatment for 1 or more lacerations (cuts) within 3 days after the accident. This benefit is payable only once per covered person, per calendar year.

2. **Burns:** We pay the amount shown on page 3B if a covered person receives treatment for 1 or more burns, other than sun burns, within 3 days after the accident. This benefit is payable only once per covered person, per accident.

3. **Skin Graft:** We pay the amount shown on page 3B if a covered person receives a skin graft for a burn for which a benefit is paid under the Burns benefit. The skin graft must be performed within 90 days after the accident. This benefit is payable only once per covered person, per accident.

4. **Brain Injury Diagnosis:** We pay the amount shown on page 3B upon the first diagnosis of 1 of the following traumatic brain injuries by a covered person: concussion, cerebral laceration, cerebral contusion, or intracranial hemorrhage. The covered person must be first treated by a physician within 3 days after the accident.

   The covered traumatic brain injury must be diagnosed within 30 days after the accident by computed tomography (CT) scan, magnetic resonance imaging (MRI), electroencephalogram (EEG), positron emission tomography (PET) scan, or X-ray. This benefit is payable only once per covered person.

5. **Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI):** We pay the amount shown on page 3B if a covered person receives a CT scan or MRI within 180 days after the accident. The covered person must be first treated by a physician within 30 days after the accident. This benefit is payable only once per covered person, per accident, per calendar year.

6. **Paralysis:** We pay the amount shown on page 3B if a covered person receives a spinal cord injury resulting in the complete and permanent loss of use of 2 or more limbs as a result of an injury. Paralysis must be confirmed by the attending physician within 3 days after the accident and have a duration of at least 90 consecutive days. This benefit is payable only once per covered person.

7. **Coma with Respiratory Assistance:** We pay the amount shown on page 3B if a covered person is in a coma. This benefit is payable only once per covered person.

   "Coma" means a continuous state of profound unconsciousness which lasts 7 or more consecutive days as a result of an accident. A coma is characterized by an absence of spontaneous eye movements, response to painful stimuli and vocalization. The condition must require intubation for respiratory assistance. Medically induced comas are excluded.

8. **Open Abdominal or Thoracic Surgery:** We pay the amount shown on page 3B if a covered person undergoes open abdominal or thoracic surgery for internal injuries within 3 days of the accident. We pay this benefit even if no surgical repair is required.

   If 2 or more surgical procedures are performed through the same incision or entry point, they are considered 1 operation.

9. **Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery:** We pay the amount shown on page 3B if a covered person undergoes a surgical procedure to repair an injury to a tendon, ligament, rotator cuff or knee cartilage. The injured site must be torn, ruptured, or severed and the surgical procedure must be performed by a physician within 180 days after the accident.

   If exploratory surgery using arthroscopy is performed and no surgical repair is required then we will pay the amount shown on page 3B. If 2 or more surgical procedures are performed through the same incision or entry point, they are considered 1 operation and we will pay the amount for the procedure with the largest dollar amount benefit.

BENEFIT ENHANCEMENTS (Continued)

10. **Ruptured Disc Surgery:** We pay the amount shown on page 3B if a covered person undergoes a surgical procedure to repair a ruptured disc of the spine. The ruptured disc must be diagnosed and the surgical procedure must be performed by a physician within 180 days after the accident.

    If 2 or more surgical procedures are performed through the same incision or entry point, they are considered 1 operation.

11. **Eye Surgery:** We pay the amount shown on page 3B for surgery or removal of a foreign object from the eye of a covered person. The procedure must be performed by a physician within 90 days after the accident. An examination with or without anesthesia is not considered surgery. This benefit is payable only once per covered person, per accident.

12. **General Anesthesia:** We pay the amount shown on page 3B if a covered person received general anesthesia administered by a nurse anesthetist or physician for surgery required to treat an injury provided a benefit is paid for the surgery under the Surgery benefit of the policy. The surgery must be performed by a physician within 180 days after the accident.

    "General Anesthesia" means a process that produces loss of consciousness, in addition to pain relief and paralysis of skeletal muscle over the entire body, by the administration of anesthetic drugs and is used during major and other invasive surgical procedures.

13. **Blood and Plasma:** We pay the amount shown on page 3B if a covered person receives a blood or plasma transfusion within 3 days after an accident. This benefit is payable only once per covered person, per accident.

14. **Appliance:** We pay the amount shown on page 3B if a covered person receives 1 of the following medical appliances prescribed by a physician as an aid in personal locomotion or mobility: wheelchair, crutches, or walker. The use of a medical appliance must begin within 90 days after the accident. This benefit is payable only once per covered person, per accident.

15. **Medical Supplies:** We pay the amount shown on page 3B for over-the-counter medical supplies purchased for a covered person provided a benefit is paid for the accident under the Accident Physician Treatment or X-Ray benefits. The supplies must be purchased within 90 days after the accident. We pay this benefit once per covered person, per accident.

16. **Medicine:** We pay the amount shown on page 3B per accident for prescription or over-the-counter medicine purchased for a covered person provided a benefit is paid for the accident under the Accident Physician Treatment or X-Ray benefits. The medicine must be purchased within 90 days after the accident. We pay this benefit once per covered person, per accident.

17. **Prosthesis:** We pay the amount shown on page 3B for a prosthetic arm, leg, hand, foot or eye prescribed by a physician to replace an arm, leg, hand, foot or eye that a covered person loses as a direct result of an accident. This benefit is paid only if a benefit is paid for the loss of an arm, leg, hand, foot or eye under the Dismemberment benefit. The prosthetic device must be received within 180 days after the accident. This benefit is payable only once per covered person, per accident.

18. **Physical Therapy:** We pay the amount shown on page 3B per day for physical therapy treatment received by a covered person when prescribed by a physician for an injury, provided a benefit is paid for the accident under the Accident Physician Treatment or X-Ray benefits. We pay for 1 physical therapy treatment per day for up to a maximum of 6 treatments per accident per covered person. Chiropractic services are excluded.

    Physical therapy must be for injuries sustained in an accident and must:
    a. begin within 90 days after the accident; and
    b. take place no longer than 6 months after the accident.

    This benefit is not payable for the same visit for which the Accident Follow-Up Treatment benefit is paid.

    "Physical Therapist" means a licensed specialist in physical therapy. The term "Physical Therapist" does not include: a chiropractor; any covered person; or any spouse, parent, brother, sister or child of a covered person.

BENEFIT ENHANCEMENTS (Continued)

19. **Rehabilitation Unit:** We pay the amount shown on page 3B per day if a covered person is confined to a rehabilitation unit as a result of an injury, provided that the covered person has been hospital confined immediately prior to being transferred to the rehabilitation unit. This benefit is paid for each day a room charge is incurred, up to 30 days for each covered person, per continuous period of rehabilitation unit confinement, for a maximum of 60 days per calendar year. This benefit is not payable for days on which the Hospital Confinement benefit is paid.

20. **Non-Local Transportation:** We pay the amount shown on page 3B per trip for non-local treatment of a covered person at a hospital or other specialized freestanding treatment center prescribed by a physician when the same or similar treatment cannot be obtained locally. "Non-local" means a one-way trip of 100 miles or more from the covered person's home to the nearest treatment facility. We do not pay for visits to a physician's office or clinic or for services other than actual treatment. This benefit is payable up to 3 times per accident. Transportation by ground or air ambulance is not covered under this benefit.

21. **Family Member Lodging:** We pay the amount shown on page 3B per day for the lodging of 1 adult family member of the covered person's family to be with the covered person when a covered person is confined for treatment in a non-local hospital or other specialized freestanding treatment center. This benefit is payable for up to 30 days for each accident.

    This benefit is only payable if the Non-local Transportation benefit is paid. This benefit will not be paid if the family member lives within 100 miles one-way of the treatment facility.

22. **Post-Accident Transportation:** We pay the amount shown on page 3B if a covered person is hospital confined for at least 3 consecutive days due to an injury resulting from an accident which occurs more than 250 miles from his or her place of residence and the covered person is brought home by a common carrier.

    "Common carrier" means a method of transport with defined published routes, time schedules and rates approved by regulators. These include public airlines, railroads, and bus lines. Travel to the place of residence must take place within 48 hours following discharge from the hospital. This benefit is payable for the injured covered person only, and only if the Hospital Confinement benefit is paid. This benefit is payable only once per covered person, per calendar year.

23. **Accident Follow-Up Treatment:** We pay the amount shown on page 3B per day for follow-up treatment received by a covered person provided a benefit is paid for the accident under the Accident Physician Treatment or X-Ray benefits. We pay for 1 follow-up treatment per day for up to a maximum of 2 treatments per accident per covered person.

    Treatments must be administered by a physician in a physician's office or in a hospital on an outpatient basis and must be for injuries sustained in an accident and must:
    a. begin within 90 days after the accident; and
    b. take place no longer than 6 months after the accident.

    This benefit is not payable for the same visit for which the Physical Therapy benefit is paid.

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SCHEDULE OF BENEFITS AND FACTORS

For the Loss of:	Factor
Life	1.00
Both Eyes	1.00
One Eye	0.50
Both Hands or Both Arms	1.00
Both Feet or Both Legs	1.00
One Hand or Arm and One Foot or Leg	1.00
One Hand or One Arm	0.50
One Foot or One Leg	0.50
One or more entire Toes	0.10
One or more entire Fingers	0.10

For the Complete Dislocation of:	Factor
Hip Joint	1.00
Knee Joint (except Patella)	0.40
Bone or Bones of the Foot, other than Toes	0.40
Ankle Joint	0.40
Wrist Joint	0.35
Elbow Joint	0.30
Shoulder Joint	0.20
Bone or Bones of the Hand, other than Fingers	0.15
Collar Bone	0.15
Two or more Fingers	0.07
Two or more Toes	0.07
One Finger or One Toe	0.03

For Complete, Simple or Closed Fracture of Bone or Bones of:	Factor
Skull (except bones of face or nose)	0.95
Hip, Thigh (Femur)	1.00
Pelvis (except Coccyx)	1.00
Arm, between Shoulder and Elbow (shaft)	0.55
Shoulder Blade (Scapula)	0.55
Leg (Tibia or Fibula)	0.55
Ankle	0.40
Knee Cap (Patella)	0.40
Collar Bone (Clavicle)	0.40
Forearm (Radius or Ulna)	0.40
Foot (except Toes)	0.35
Hand or Wrist (except Fingers)	0.35
Lower Jaw (except Alveolar Process)	0.20
Two or More Ribs, Fingers or Toes	0.15
Bones of Face or Nose	0.15
One Rib, Finger or Toe	0.07
Coccyx	0.07

CONTINUATION OF INSURANCE COVERAGE

This section provides for automatic Continuation of Insurance Coverage, hereafter referred to as Continuation Coverage. It applies if a covered person suffers the loss of this group health insurance coverage due to one of the following events:

1. Termination of your employment; or your eligibility due to reduction in your hours; or the date you are no longer in an eligible class; or the date your class is no longer eligible. Insurance may be continued for any covered person.
2. Your death. Insurance may be continued for any covered person.
3. Divorce or legal separation. Insurance may be continued for any covered person whose insurance would otherwise end.
4. Your becoming eligible for Medicare. Insurance may be continued for any covered person who is not entitled to Medicare.
5. A child ceasing to be an eligible dependent as defined in the group policy. Insurance may continue for that child.
6. The policyholder filing a Chapter 11 Bankruptcy petition. Insurance may be continued for any insured retiree and his or her covered dependents. But this only applies if the insurance ends or is substantially reduced within 1 year before or after the filing of the bankruptcy.
7. Termination of the group policy. (Benefits will be determined as if the group policy had remained in full force and effect.)
8. Military Service. Your leave of absence due to military service. Insurance may be continued for any covered person, except for the person who is in active military service.

Continuation Coverage is not available for any person if coverage under the group policy terminated due to your failure to make required premium payments.

Continuation Coverage is not available to any person who is on FMLA. Continuation Coverage is also not available if a person fails to pay premium while on FMLA.

To be eligible for Continuation Coverage, a person must be insured under the group policy on the day before the event that caused loss of coverage. In the case of bankruptcy, the person must also be: (a) an employee or member who retired on or before the date insurance ends or is substantially reduced; or (b) a dependent of the retiree on the day before the bankruptcy.

A person will not be denied Continuation Coverage solely because he or she is covered under another group health plan like this one, or eligible for Medicare on the date of the event that caused loss of coverage.

COVERAGE CONTINUED

The Continuation Coverage may include any eligible dependents who were covered under the group policy. The coverage being continued is subject to all terms and provisions of the group policy that do not conflict with this section. The coverage will be the same as that provided under the group policy for other persons in the same insurance class in which such person would have been if the loss of coverage had not occurred. The coverage will be subject to any changes to the group policy affecting the benefits of such class. The coverage will be effective on the day after the insurance under the group policy terminates.

NOTIFICATION AND PAYMENT REQUIREMENTS

You or other qualifying dependents have the responsibility to inform the insurer of (a) divorce; (b) legal separation; or (c) a child losing eligibility under the policy. This notice must be made within 60 days of these events. Failure to provide this notification within 60 days will result in the loss of the right to continue the insurance.

The policyholder has the responsibility of notifying the insurer of (a) an insured's death, termination of employment, or reduction in hours; or (b) the policyholder's bankruptcy. This notice must be made within 30 days of the event.

The insurer will notify the qualifying person of the right to continue within 14 days of the notice described above.

The qualifying person will be required to pay a premium for the Continuation Coverage to the insurer.

CONTINUATION OF INSURANCE COVERAGE (Continued)

PREMIUMS

Premiums are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The premium rate for the first 36 months of Continuation Coverage will not exceed 102% of the rate in effect under the group policy covering similarly situated class of employees who have not elected Continuation Coverage. After the first 36 months, the premium rate may change for the class of persons covered under Continuation Coverage. Written notice will be given at least 31 days before any change is to take effect.

GRACE PERIOD

The grace period, as defined in the group policy, will apply to each certificate holder of Continuation Coverage as if such insured is the policyholder.

TERMINATION OF INSURANCE

Insurance under Continuation Coverage will automatically end on the earliest of the following dates:

1. The date the person again becomes eligible for insurance under the group policy.
2. The last day for which premiums have been paid, if the insured fails to pay premiums when due, subject to the grace period.
3. With respect to insurance for dependents:
   a. the date your insurance terminates; or
   b. the date the dependent ceases to be an eligible dependent under the group policy.

A dependent child whose Continuation Coverage terminates when he or she reaches the age limit may apply for Continuation Coverage in his or her own name, if he or she is otherwise eligible.

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CLAIM INFORMATION

NOTICE OF CLAIM

We encourage you to notify us of a claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of claim must be given to us within 20 days after the occurrence or commencement of any benefit covered by the policy, or as soon as is reasonably possible. Notice given to us by, or on behalf of, you or the beneficiary at 1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687, or to any authorized agent of ours, with your name and certificate number, is notice to us.

FILING A CLAIM

The claim form can be requested from us. If the claim form is not received within 15 days of the request, you shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

You must complete all applicable sections of the claim form and then give it to your attending physician. The physician should complete his or her section statement of the form and send it directly to us.

PROOF OF YOUR CLAIM

If this certificate provides for periodic payment of a continuing loss, written proof of loss must be furnished to us within 90 days after the end of each period for which we are liable. For any other loss, written proof must be given to us within 90 days after each loss. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 1 year from the time specified unless you are legally incapacitated.

PHYSICAL EXAMINATION AND AUTOPSY

We have the right, at our own expense, to have any covered person examined by a physician of our choosing, as often as may be reasonably required while a claim is pending. We may have an autopsy performed during the period of contestability, where it is not forbidden by law.

PAYMENT OF CLAIMS

After receiving written proof of claim, we will immediately pay all benefits then due under this certificate and we will make payments to you. Any amounts unpaid at your death may, at our option, be paid either to the named beneficiary or to your estate.

If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to $1,000, to someone related to you or your beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

ASSIGNMENT

An assignment of the coverage under this certificate is not binding on us, unless:

1 it is a written request; and
2 it is received and recorded by us at our home office.

We are not responsible for the validity of any assignment. An assignment is subject to any payment we make or other action we take before we record the assignment. An assignment may not change the owner or beneficiary.

CLAIM INFORMATION – (Continued)

OVERPAID CLAIM

We have the right to correct benefit payments that are made in error. You have the responsibility to return any overpayment to us. We have the responsibility to make additional payments if any underpayments have been made.

CLAIM REVIEW

If a claim is denied, we will give written notice of:

1. the reason for denial; and
2. the policy provision that relates to the denial; and
3. your right to ask for a review of your claim; and
4. any additional information that might allow us to change our decision.

You may, upon written request, read any reports that are not confidential. For a small fee, we will make copies of those reports for your use.

APPEALS PROCEDURE

Prior to filing any lawsuit and within 60 days after denial of a claim, you or your beneficiary must appeal any denial of benefits under the policy by making a written request for review of the denial.

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GLOSSARY

Accident means a sudden, unforeseen and unexpected event which occurs without the covered person's intent which results in an injury to the covered person independent of disease, bodily infirmity, or any other cause.

Active Employment means you are working for your employer for earnings that are paid regularly and that you are performing the material and substantial duties of your own occupation. For the purposes of this coverage:

1. you must be working at least the minimum number of hours as described under Eligible Class(es); and
2. you will be deemed to be in active employment on a day which is not your employer's scheduled work days only if you were an active employee on the preceding scheduled work day.

Your work site must be:

1. your employer's usual place of business; or
2. an alternative work site at the direction of your employer; or
3. a location to which your job requires you to travel.

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. Temporary and seasonal workers are excluded from coverage.

Calendar Year means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

Common Carrier means only the following: commercial airlines; or passenger trains; or intercity buslines. It does not include taxis; or intracity buslines; or private charter planes.

Covered Person means any of the following:

1. any eligible family member (including you) named in the enrollment form or evidence of insurability form and acceptable for coverage by us; or
2. any eligible family member added by endorsement after the effective date; or
3. a newborn child.

Day means a 24 hour period.

Domestic Partner means your same-sex or opposite-sex partner who is eligible for coverage provided that:

1. both you and your same-sex or opposite-sex partner must be considered as domestic partners according to the law of your state of residence; or
2. if your state of residence has no domestic partnership laws, you must satisfy the definition of domestic partner as defined by the policyholder.

Eligibility Waiting Period means the continuous period of time that you must be in active employment in an eligible class before eligible for coverage under the policy.

Employee means a person who is a citizen or resident of the United States or Canada in active employment with his or her employer.

Employer means the individual, company or corporation where the covered person is in active employment, and includes any division, subsidiary, or affiliated company of the employer.

Grace Period means the 31 day period of time following the premium due date during which premium payment may be made.

GLOSSARY (Continued)

Hospital means a legally operated institution with established facilities (either on its premises or available to the hospital on a contractual, pre-arranged basis and under the supervision of a staff of one or more duly licensed physicians), for the care and treatment of sick and injured persons for diagnosis, surgery, and 24 hour nursing service. Hospital does not include:

1. any institution which is mainly a rest home, nursing home, convalescent home, or home for the aged; or
2. any institution which is mainly for the care and treatment of alcoholics or drug addicts, or mental or nervous disorders.

Initial Enrollment Period means one of the following periods during which you may first apply in writing for coverage under the policy:

1. if you are eligible for coverage on the policy effective date, a period before the policy effective date as set by us and by the employer; or
2. if you become eligible for coverage after the policy effective date, the period ending 31 days after the date you are first eligible to apply for coverage.

Injury means accidental bodily injury to a covered person, as the result of an accident while coverage under this certificate is in force, and the injury is the direct cause of the loss independent of disease, bodily infirmity, or any other cause which results:

1. in a loss of life or by dismemberment within 180 days after the date the injury is sustained; or
2. in expenses incurred for medical treatment within 90 days after the injury is sustained.

All injuries sustained in any one accident and all complications and recurrences of complications are considered to be a single “injury”.

Issue Day means the same day of the month as the effective date of coverage.

Insured Employee or Member means the employee or member covered under the policy.

Material and Substantial Duties means duties that:

1. are normally required for the performance of the covered person’s regular occupation; and
2. cannot be reasonably omitted or modified, except that if the covered person is required to work on average in excess of 40 hours per week. We will consider the covered person able to perform that requirement if he/she is working or has the capacity to work 40 hours per week.

Member means a member in good standing in the labor union or association named as the policyholder and who is : (a) a citizen or resident of the United States; and (b) is (i) engaged in, or (ii) able to engage in and currently seeking, active employment.

Off The Job Accident means any accident that is not an on the job accident.

On The Job Accident means an accident which occurs during the course of a covered person’s working for pay or profit. If the covered person is covered by workers’ compensation, the accident is an on the job accident. If the covered person is not covered by workers’ compensation and the injury occurs while the covered person is working for pay or profit in the course of the covered person’s regular and/or part time occupation, the accident is an on the job accident.

Payable Claim means a claim for which we are liable under the terms of the policy.

Physician means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person who is a legally qualified medical practitioner according to the laws and regulations of the state he or she practices in.

We will not recognize you, your spouse or Domestic Partner, children, parents, or siblings as a physician for a claim.

Policyholder means the legal entity to whom the policy is issued.

GLOSSARY (Continued)

Temporary Layoff or **Leave of Absence** or **Family and Medical Leave of Absence** means you are absent from active employment for a period of time that has been agreed to in advance in writing by your employer.

Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

We, Us and **Our** mean American Heritage Life Insurance Company.

You and **Your** mean the named insured employee or member shown on page 3 who is a member of an eligible class as described in the policy and for whom premiums are remitted.

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AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

THIS IS GROUP ACCIDENT ONLY COVERAGE WHICH PROVIDES BENEFITS FOR OFF THE JOB ACCIDENTS AS DEFINED WITHIN THIS CERTIFICATE OR OTHER BENEFITS THAT MAY BE ADDED. THIS COVERAGE DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.

Important Privacy Policy Notice

At Allstate Benefits ("AB"), we value you as a customer. We also share your concerns about privacy. We are sending this notice to explain how we treat personal information ("customer information") that is not public. This is information that we obtain from you or other sources when we provide you with products and services.

We want you to know that: we respect your privacy; and we protect your information.

- We do not sell customer information.
- We do not share your information with: persons; companies; or organizations outside of AB that would use that information to contact you about their products and services.
- We expect persons or organizations that provide services on our behalf to keep your information confidential. We also expect them to use your information only to provide the services we've asked them to perform.
- We communicate to our employees about the need to protect your information. We have established safeguards (these are physical, electronic and procedural) to protect this information.

Below are answers to questions that you might have about privacy. You may be wondering...

What do we do with your information?

AB does not sell your customer or medical information to anyone. We do not share it with companies or organizations outside of AB that would use that information to contact you about their own products and services. If this were to change, we would offer you the option to opt out of this type of information sharing. Also, we would obtain your consent before we share medical information for marketing purposes.

Your agent or broker may use your information to help you with your insurance needs. We may also communicate with you about products, features, and options in which you have expressed an interest. Without your consent, we may provide your information to persons or organizations in and out of AB. This would be done as permitted or required by law. We may do this to:

- Fulfill a transaction you have requested.
- Service your policy.
- Market our products to you.
- Investigate or handle claims.
- Detect or prevent fraud.
- Participate in insurance support organizations (Information from a report by an insurance support organization may be retained by that organization and distributed to other persons.).
- Comply with lawful requests from regulatory and law enforcement authorities.

These persons or organizations may include:

- Our affiliated companies.
- Companies that perform services, including marketing, on our behalf.
- Other financial institutions with which we have an agreement for the sale of financial products.
- Other insurance companies to perform their role in an insurance transaction involving you.
- Businesses that conduct actuarial or research studies.
- Persons requesting information pursuant to a subpoena or court order.
- Your agent or broker.
- An employer, if your premiums are payroll deducted.
- The creditor who sold you insurance, if your policy is credit insurance.

What kind of customer information do we have, and where did we get it?
Much of the information that we have about you comes from you. When you perform certain transactions, you may give us information such as your name, address, and Social Security number. These transactions include when you submit: an application for insurance; a request for insurance; a request for products and services we offer; or a request for an insurance quote. We may have contacted you by telephone or mail for additional information. We keep information about the types of services you purchase from us and our affiliates. Examples of this include premiums, fund values, and payment history. We may collect information from outside sources such as consumer reporting agencies and health care providers. The information we collect may include the following:

- Motor vehicle reports.
- Credit reports.
- Medical information.

How do we protect your customer information?
We expect any company with whom we share your information to use it only to provide the service we have asked them to perform. Information about you is also available within AB to those individuals who may need to use it to fulfill and service the needs of our customers. We communicate the need to protect your information to all employees and agents. We especially communicate this need to individuals who have access to it. Plus, we have established physical, electronic, and procedural safeguards to protect your information. Note that if your relationship with us ends, your information will remain protected. This protection will be provided according to our privacy practices outlined in this Important Notice.

How can you find out what information we have about you?
You may request to see, or obtain by mail, the information about you in our records. If you believe that our information is incomplete or inaccurate, you may request that we correct, add to, or delete from the disputed information. In order to fulfill your request, we may make arrangements to copy and disclose your information to you on our behalf. This may be done with an insurance support organization or a consumer reporting agency. You may also request a more complete description of the entities to which we disclose your information, or the conditions that might warrant such disclosures. Please send any of the requests listed above in writing to:

AB
Policyholder Services (Privacy Section)
1776 American Heritage Life Drive
Jacksonville, FL 32224-6687

If you are an Internet user …
Our website, www.allstateatwork.com, provides information about AB, our products, and the agencies and brokers that represent us. You may also perform certain transactions on the website. When accessing www.allstateatwork.com, please be sure to read the Privacy Statement that appears there. To learn more, the www.allstateatwork.com Privacy Statement provides information relating to your use of the website. This includes, for example:

1) our use of online collecting devices known as “cookies”;
2) how we collect information such as IP address (the number assigned to your computer when you use the Internet), browser and platform types, domain names, access times, referral data, and your activity while using our site;
3) who should use our website;
4) the security of information over the Internet;
5) links and co-branded sites.

We hope you have found this notice helpful. If you have any questions or would like more information, please don’t hesitate to contact your agent or write us at:

AB
Policyholder Services (Privacy Section)
1776 American Heritage Life Drive
Jacksonville, FL 32224-6687

This notice is being provided on behalf of the following companies:

American Heritage Life Insurance Company
Bluegrass Life Insurance Company
Acme United Insurance Company
SMA Life Assurance Company
Holiday Life Insurance Company
Kentucky Home Mutual
Keystone State Life
National Guardian Life

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE APRIL 14, 2003

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of our Plan's customers' Protected Health Information, to provide those customers with notice of our legal duties and privacy practices with respect to Protected Health Information, and to send notification to affected customers if there is a breach of unsecured Protected Health Information. If your state provides privacy protections that are more stringent than those provided by HIPAA, we will maintain your Protected Health Information in accordance with the more stringent state standard.

This Notice applies to "Protected Health Information" associated with "Health Plans" issued by American Heritage Life Insurance Company.

This Notice describes how we may use and disclose Protected Health Information to perform claims handling, payment, general insurance operations, and for other purposes that are permitted or required by law. Use or disclosure of your Protected Health Information for the purposes described in this Notice may be made in writing, orally, or by electronic means.

We are required to abide by the terms of this Notice. However, we may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all of your Protected Health Information that we maintain, including any information we created or received prior to issuing the new notice. If we make a material revision to our Privacy Notice, copies will be sent to you if you are then currently insured under our Plan.

Protected Health Information means information about you that is created or received by us and during the administration of coverage under the Plan, which identifies you or for which there is a reasonable basis to believe the information can be used to identify you and that relates to:

1) the past, present or future physical or mental health condition of the individual; or
2) the provision of health care to the individual; or
3) the past, present or future payment for the provision of health care to the individual.

Uses and Disclosures of Protected Health Information With Your Written Authorization

Except as described in the next section of this Notice, we will not use or disclose your Protected Health Information for any purpose unless you have signed a form authorizing the use or disclosure. For example, most uses and disclosures of psychotherapy notes, uses and disclosures of Protected Health Information for marketing purposes, and disclosures that constitute a sale of Protected Health Information will be made only with your authorization. You have the right to revoke that authorization in writing at any

time, except to the extent that we have already taken action in reliance on the authorization; or the authorization was obtained as a condition of obtaining coverage, to the extent that other law allows the insurer to contest a claim under the policy or the policy itself.

Uses and Disclosures of Protected Health Information Without Your Written Authorization

For Payment. We may make use of and disclose your Protected Health Information without your written authorization as may be necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims or certify these services are covered under your Plan.

For Plan Administrative Operations. We may make use of and disclose your Protected Health Information without your written authorization as necessary for our Plan administrative operations. Plan administrative operations include our usual business activities, examples of which are management, licensing, peer review, quality improvement and assurance, enrollment, underwriting, reinsurance, compliance, auditing, rating, claims handling, complaint handling and other functions related to your Plan. We are prohibited from using or disclosing genetic information for underwriting purposes.

To Individuals Involved In Your Care. We may, without your written authorization, for the purposes of treatment, payment or Plan administrative operations, disclose the fact that you are covered under a Plan or that payment has been processed to a family member, other relative, your close personal friend or any other person you may identify. In these circumstances, we would not disclose any Protected Health Information which is not directly relevant to that person's involvement with your care or with payment for your care.

If you have designated a person to receive information regarding payment of the premium or pay premium via credit card, we may inform that person or credit card facility when your premium has not been paid or received by us.

We may also disclose limited Protected Health Information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

To Our Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations. Examples of these may include, but are not limited to our duly appointed insurance agents, financial auditors, reinsurers, legal services, enrollment and billing services, claim payment and medical management services. We may provide access to your Protected Health Information without your written authorization to one or more of these outside persons or organizations who assist us with payment or Plan administrative operations. We require these business associates to appropriately safeguard the privacy of your information.

To Plan Sponsors. If you are enrolled in a group health plan, we may share summary health information with your employer, union, or other employee organization that sponsors and maintains the group health plan, for purposes of obtaining premium bids; or modifying, amending, or terminating the group health plan; or enrollment and disenrollment information. Summary health information excludes genetic information.

For Other Products and Services. We may contact you without your written authorization to provide information regarding Plan upgrades or additional benefits that may be of interest to you. For example, we may use the fact that you currently are insured under a Plan for the purpose of communicating to you about changes to our Plan or products that could enhance or add value to existing coverage.

For Disclosure With Authorization. Unless otherwise excluded in this notice, we will not disclose any other Protected Health Information to any person or entity not specifically mentioned elsewhere in this Notice without your express written authorization.

For Other Uses and Disclosures. We are permitted or required by law to make some other uses and disclosures of your Protected Health Information without your authorization. We may release your Protected Health Information:

- if required by law to a government authorized health oversight agency or company conducting audits, investigations, or civil or criminal proceedings.

- if required to do so by a court or administrative ordered subpoena or discovery request. In most cases you will have notice of such a release.

- for public health activities, such as required reporting of disease, injury, birth and death and for required public health investigations.

- as required by law if we suspect child abuse or neglect or if we believe you to be a victim of abuse, neglect or domestic violence.

- to the Food and Drug Administration if necessary to report adverse events, product defects or to participate in product recalls.

- to law enforcement officials as required by law to report wounds, injuries or crimes.

- to coroners, medical examiners and/or funeral directors consistent with law.

- for a national security or intelligence activity or, if you are a member of the military, as required by the armed forces.

- to workers' compensation agencies or similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Your Rights

Right to Inspect and Copy Your Protected Health Information. You may have access to our records that contain your Protected Health Information in order to inspect and obtain copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from our Privacy Officer and submit the completed form to our Privacy Office. If you request copies, we may charge you copying and mailing costs. If you request a copy of your Protected Health Information in electronic form, we will provide it to you electronically only if the record is readily producible in electronic form.

Right to Amend Your Protected Health Information. You have the right to request that we amend your Protected Health Information maintained in our enrollment, payment, claims adjudication and case or medical management records, or other records we use to make decisions about you. If you desire to amend these records, please obtain an amendment request form from our Privacy Officer and submit the completed form to our Privacy Office. We will comply with your request unless special circumstances apply. If your physician or other health care provider created the information that you desire to amend, you should contact the provider to amend the information.

Right to an Accounting of the Disclosures of Your Protected Health Information. Upon request, you may obtain an accounting of certain disclosures of your Protected Health Information made by us on or after April 14, 2003, excluding disclosures made earlier than six years before the date of your request. If you request an accounting more than once during any 12 month period, we will charge you a reasonable fee for the subsequent accounting statements.

Right to Request Confidential Communications. We will accommodate your reasonable request to receive communications of your Protected Health Information from us by alternative means of communication or at alternative locations if the request clearly states that disclosure of that information could endanger you.

Right to Request Restrictions on Use and Disclosure of Your Protected Health Information. You have the right to request restrictions on some of our uses and disclosures of your Protected Health Information to family members and others involved in your care or payment for care; or some of our uses and disclosures used to carry out treatment, payment, or Plan administrative operations, by notifying us of your request for a restriction in writing mailed to the contact identified at the end of this Notice. Your request must describe in detail the restriction you are requesting. We are not required to agree to your restriction request but will attempt to accommodate your requests. We retain the right to terminate an agreed-to restriction. In the event of a termination of an agreed-to restriction by us, we will notify you of such termination, but the termination will only be effective for Protected Health Information we receive after we have notified you of the termination. You also have the right to terminate any agreed-to restriction by contacting us using the "Contact Information" provided at the end of this Notice.

Personal Representatives. You may exercise your rights through a personal representative who will be required to produce evidence of his or her authority to act on your behalf. Proof of authority may be made by a notarized power of attorney, a court order of appointment of the person as your legal guardian or conservator, or if you are the parent of a minor child. We reserve the right to deny access to your personal representative.

Right to Receive Paper Copy of this Notice. You may obtain a copy of this Notice. You may obtain a paper copy of this Notice even if you agreed to receive such notice electronically. Please contact us and we will mail it to you.

Complaints

If you believe your privacy rights have been violated, you can file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Plan, send it in writing to the "Contact Information" at the address listed at the end of this Notice. There will be no retaliation for filing a complaint.

You may obtain a copy of this Notice by writing to us at the contact address below.

Contact Information

If you have questions or need further assistance regarding this Notice, you may contact:

Allstate Benefits
Attn: HIPAA Privacy Officer
1776 American Heritage Life Drive
Jacksonville, Florida 32224

Or, you may telephone the Customer Care Center at 1-800-521-3535.

GENERAL PURPOSES AND LIMITATIONS OF THE
KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
K.S.A. 40-3001 et. seq.

DISCLAIMER

THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MAY NOT PROVIDE COVERAGE FOR ALL OR A PORTION OF THIS POLICY. IF COVERAGE IS PROVIDED, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS AND EXCLUSIONS, AND IS CONDITIONED UPON RESIDENCY IN THIS STATE. THEREFORE, YOU SHOULD NOT RELY UPON COVERAGE BY THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELECTING AN INSURANCE COMPANY OR IN SELECTING AN INSURANCE POLICY. INSURANCE COMPANIES AND THEIR AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELLING YOU ANY FORM OF AN INSURANCE POLICY, OR TO INDUCE YOU TO PURCHASE ANY FORM OF AN INSURANCE POLICY. EITHER THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE KANSAS INSURANCE DEPARTMENT WILL RESPOND TO ANY QUESTIONS YOU MAY HAVE REGARDING THIS DOCUMENT.

Kansas Life and Health Insurance Guaranty Association
2909 SW Maupin Lane
Topeka, KS 66614

Kansas Insurance Department
420 SW 9th Street
Topeka, KS 66612

This is a brief summary of the Kansas Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. If there is any inconsistency between this notice and Kansas law, then Kansas law will control.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Kansas law, with funding from assessments paid by other insurance companies. This safety net was created under Kansas law, which determines who and what is covered and the amounts of coverage. The basic protections provided by the Association are:

- Life Insurance
  $300,000 in death benefits
  $100,000 in cash surrender or withdrawal values
- Health Insurance
  $500,000 in hospital, medical and surgical insurance benefits
  $300,000 in disability insurance benefits
  $300,000 in long-term care insurance benefits
  $100,000 in other types of health insurance benefits
- Annuities
  $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits, as well as certain aggregate limits.

AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

GROUP CRITICAL ILLNESS INSURANCE POLICY
NON-PARTICIPATING

American Heritage Life Insurance Company (referred to as we, us, or our) will provide benefits under this policy. We make this promise subject to all of the provisions of this policy.

The policyholder should read this group policy carefully and contact us promptly with any questions. This group policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA), and consists of:

1. all policy provisions and any amendments and/or attachments issued; and
2. the policyholders' signed application.

This policy may be changed in whole or in part. The approval must be in writing, signed by one of our executive officers and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida on the policy effective date.

Secretary

President

THIS IS A CRITICAL ILLNESS POLICY WHICH PROVIDES STATED BENEFITS FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED. THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.

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POLICY SPECIFICATIONS

POLICYHOLDER:	USD 262 VALLEY CENTER SCHOOL DISTRICT.
POLICY NUMBER:	20216
POLICY EFFECTIVE DATE:	APRIL 1, 2014
POLICY ANNIVERSARY DATE:	April 1, 2015 and the first day of April each calendar year thereafter.
GOVERNING JURISDICTION:	the state of Kansas and subject to the laws of that jurisdiction.

ELIGIBLE CLASS(ES): All classified and certified active employees working at least 20 hours per week.

ELIGIBILITY WAITING PERIOD: None

	PLAN I	**PLAN II**
BASIC BENEFIT AMOUNT:	$10,000 for Insured $ 5,000 for Insured Spouse $ 5,000 for Insured Child(ren)	$15,000 for Insured $ 7,500 for Insured Spouse $ 7,500 for Insured Child(ren)
GUARANTEED ISSUE LIMIT:	*$15,000	*$15,000
OPTIONAL BENEFITS:	• Second Event Initial Critical Illness Benefit • Supplemental Critical Illness Benefit II – Same as Basic Benefit amount • Wellness Benefit-$50.00 per year per insured	• Second Event Initial Critical Illness Benefit • Supplemental Critical Illness Benefit II – Same as Basic Benefit amount • Wellness Benefit-$50.00 per year per insured

	PLAN III	**PLAN IV**
BASIC BENEFIT AMOUNT:	$10,000 for Insured $ 5,000 for Insured Spouse $ 5,000 for Insured Child(ren)	$15,000 for Insured $ 7,500 for Insured Spouse $ 7,500 for Insured Child(ren)
GUARANTEED ISSUE LIMIT:	*$15,000	*$15,000
OPTIONAL BENEFITS:	• Cancer Critical Illness Benefit – Same as Basic Benefit amount • Second Event Initial Critical Illness Benefit • Supplemental Critical Illness Benefit II – Same as Basic Benefit amount • Wellness Benefit-$50.00 per year per insured	• Cancer Critical Illness Benefit – Same as Basic Benefit amount • Second Event Initial Critical Illness Benefit • Supplemental Critical Illness Benefit II – Same as Basic Benefit amount • Wellness Benefit-$50.00 per year per insured

TAKEOVER: *****Employees who were covered for amounts of insurance under the prior group critical illness policy sponsored by the policyholder in excess of $5,000, up to a maximum of $50,000, in increments of $1,000. Such employees are eligible for equal amounts of coverage under this critical illness policy. The guaranteed issue limit for employees insured under the prior group policy is their benefit amount at the time prior policy terminated.

POLICY SPECIFICATIONS (Continued)

INITIAL RATE:

Monthly rate per employee for **PLAN I:**

Premium Rates	Age	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Non-Tobacco	18-29	$2.73	$4.71	$2.73	$4.71
	30-39	$4.81	$7.84	$4.81	$7.84
	40-49	$8.03	$12.67	$8.03	$12.67
	50-59	$14.20	$21.93	$14.20	$21.93
	60-63	$23.88	$36.45	$23.88	$36.45
	64 +	$33.15	$50.35	$33.15	$50.35
Tobacco	18-29	$3.52	$5.90	$3.52	$5.90
	30-39	$6.81	$10.83	$6.81	$10.83
	40-49	$13.09	$20.27	$13.09	$20.27
	50-59	$22.55	$34.44	$22.55	$34.44
	60-63	$38.99	$59.12	$38.99	$59.12
	64 +	$54.94	$83.05	$54.94	$83.05

Monthly rate per employee for **PLAN II:**

Premium Rates	Age	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Non-Tobacco	18-29	$3.46	$5.81	$3.46	$5.81
	30-39	$6.59	$10.51	$6.59	$10.51
	40-49	$11.42	$17.75	$11.42	$17.75
	50-59	$20.68	$31.65	$20.68	$31.65
	60-63	$35.22	$53.45	$35.22	$53.45
	64 +	$49.10	$74.27	$49.10	$74.27
Tobacco	18-29	$4.66	$7.61	$4.66	$7.61
	30-39	$9.57	$14.98	$9.57	$14.98
	40-49	$19.02	$29.15	$19.02	$29.15
	50-59	$33.19	$50.42	$33.19	$50.42
	60-63	$57.88	$87.43	$57.88	$87.43
	64 +	$81.80	$123.32	$81.80	$123.32

POLICY SPECIFICATIONS (Continued)

INITIAL RATE: Monthly rate per employee for **PLAN III:**

Premium Rates	Age	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Non-Tobacco	18-29	$5.08	$8.23	$5.08	$8.23
	30-39	$8.93	$14.02	$8.93	$14.02
	40-49	$16.13	$24.82	$16.13	$24.82
	50-59	$28.30	$43.08	$28.30	$43.08
	60-63	$45.65	$69.11	$45.65	$69.11
	64 +	$59.26	$89.51	$59.26	$89.51
Tobacco	18-29	$7.39	$11.71	$7.39	$11.71
	30-39	$13.78	$21.28	$13.78	$21.28
	40-49	$28.32	$43.12	$28.32	$43.12
	50-59	$47.55	$71.94	$47.55	$71.94
	60-63	$77.96	$117.58	$77.96	$117.58
	64 +	$102.20	$153.94	$102.20	$153.94

Monthly rate per employee for **PLAN IV:**

Premium Rates	Age	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Non-Tobacco	18-29	$6.98	$11.09	$6.98	$11.09
	30-39	$12.78	$19.79	$12.78	$19.79
	40-49	$23.57	$35.97	$23.57	$35.97
	50-59	$41.83	$63.37	$41.83	$63.37
	60-63	$67.88	$102.44	$67.88	$102.44
	64 +	$88.26	$133.31	$88.26	$133.31
Tobacco	18-29	$10.47	$16.33	$10.47	$16.33
	30-39	$20.02	$30.65	$20.02	$30.65
	40-49	$41.87	$63.42	$41.87	$63.42
	50-59	$70.69	$106.67	$70.69	$106.67
	60-63	$116.34	$175.12	$116.34	$175.12
	64 +	$152.69	$229.65	$152.69	$229.65

RATE GUARANTEE DATE: 04/01/2015

PREMIUM DUE: The initial date agreed to between American Heritage Life Insurance Company and the Policyholder and each specified date thereafter.

The policyholder must send all premiums on or before the premium due date to us. The premium must be paid in United States dollars.

COST OF COVERAGE: The insured employee pays the cost of coverage**.**

POLICY SPECIFICATIONS (Continued)

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES:

These are the policyholder's divisions, subsidiaries, or affiliates listed below. The policyholder may act for and on behalf of any and all of these in all matters that pertain to this policy. Every act done by, agreement made with, or notice given to the policyholder will be binding on them.

NAME	LOCATION (CITY AND STATE)
NONE	

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POLICYHOLDER PROVISIONS

RATE GUARANTEE

A change in premium rate will not take effect before the Rate Guarantee Date except for reasons which affect the risk assumed, including those reasons shown below:

1. a change occurs in this plan design; or
2. a division, subsidiary, or affiliated company is added or deleted; or
3. the number of insured employees or members changes by 20% or more; or
4. a new law or a change in any existing law is enacted which applies to this plan; or
5. less than 20% of those eligible for coverage are participating.

We will notify the policyholder in writing at least 30 days before a premium rate is changed. A change may take effect on an earlier date when both we and the policyholder agree in writing.

PREMIUM INCREASES OR DECREASES

Premium increases or decreases may take effect any time subject to the Rate Guarantee provision. If they take effect during a policy month, they are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

INFORMATION REQUIRED FROM THE POLICYHOLDER

The policyholder must provide us with the following on a regular basis:

1. information about employees or members:
    a. who are eligible to become insured; and
    b. whose coverage changes; and
    c. whose coverage ends; and
2. any information that may be required to manage a claim; and
3. any other information that may be reasonably required.

Policyholder records that have a bearing, in our opinion, on this policy will be available for review by us at any reasonable time.

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required if:

1. the employee or member:
    a. voluntarily canceled coverage and is reapplying; or
    b. is applying for an amount of coverage over the Guaranteed Issue Limit; or
    c. is applying for the coverage, or an increase in the amount of coverage, at any time after his or her initial enrollment period.
2. an eligible dependent did not enroll within 31 days of eligibility.

POLICYHOLDER PROVISIONS (Continued)

INCONTESTABILITY

After 2 years from the effective date of this policy, no misstatement of the policyholder, made in any applications, can be used to void this policy.

CLERICAL ERROR

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by the policyholder documenting any clerical errors.

CANCELING POLICY

This policy can be canceled:
1. by us; or
2. by the policyholder.

We may cancel or offer to modify this policy, with at least 31 days written notice to the policyholder, if:
1. less than 20% of those eligible for coverage are participating; or
2. this policy has been in effect more than 12 months; or
3. the policyholder does not promptly provide us with information that is reasonably required; or
4. the policyholder fails to perform any of its obligations that relate to this policy; or
5. fewer than 20% employees or members are insured; or
6. the policyholder fails to pay any premium within the 31 day grace period.

If the premium is not paid during the grace period, this policy will terminate automatically at the end of the grace period. The policyholder is liable for the premium for coverage during the grace period. The policyholder must pay us all premiums due for the full period this policy is in force.

The policyholder may cancel this policy by written notice delivered to us at least 31 days prior to the cancellation date. When both the policyholder and we agree, this policy can be canceled on an earlier date. If canceled, coverage will end at 12:00 midnight on the last day of coverage.

If this policy is canceled, the cancellation will not affect a payable claim incurred prior to cancellation.

ENTIRE CONTRACT

The contract consists of the following items:
1. the group policy; and
2. any amendments and endorsements; and
3. the applications and other written statements of the policyholder; and
4. any individual applications, enrollments, evidence of insurability or other statements of the insured employee or member.

Any statements made by the policyholder or by a covered person, in the absence of fraud, are representations and not warranties. Only written statements signed by the policyholder or a covered person will be used in defense of a claim. A copy of any written statement, if applicable, will be furnished to the policyholder or the covered person or his or her personal representative, if any, if such written statement will be used in defense of a claim.

CERTIFICATES OF INSURANCE

We will issue certificates of insurance for each insured employee or member. The certificate will provide a description of the insurance provided by this policy and will state:
1. the benefits provided; and
2. to whom benefits are payable; and
3. the limitations, exclusions and requirements that apply to coverage under this policy.

If there is any discrepancy between the provisions of any certificate and the provisions of this policy, the provisions of this policy govern.

GLOSSARY

Active Employment. Means the employee or member is working for the employer for earnings that are paid regularly and that he or she is performing the material and substantial duties of his or her regular occupation. For the purposes of this policy:

1. the employee or member must be working at least the minimum number of hours as described under Eligible Class(es); and
2. the employee or member will be deemed to be in active employment on a day which is not the employer's scheduled work days only if he or she was actively employed on the preceding scheduled work day.

The employee's or member's work site must be:

1. the employer's usual place of business; or
2. an alternative work site at the direction of the employer; or
3. a location to which the job requires such employee or member to travel.

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. Temporary and seasonal workers are excluded from coverage.

Calendar Year. Means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

Eligibility Waiting Period. Means the continuous period of time that the employee or member must be in active employment in an eligible class before he or she is eligible for coverage.

Employee. Means a person who is: (a) a citizen or resident of the United States or one of its territories; and (b) in active employment with the employer or is a member in good standing in the labor union, association or other entity named as the policyholder.

Employer. Means the individual, company or corporation where the employee or member is in active employment, and includes any division, subsidiary, or affiliated company named in this policy.

Evidence of Insurability. Means a statement of the employee's or member's or a dependent's medical history which we will use to determine if he or she is approved for coverage. Evidence of insurability will be provided at such person's expense.

Family Coverage. Means coverage that includes the insured employee or member as defined, his or her eligible spouse and children as described in the certificate.

Grace Period. Means a period of 31 days following the premium due date during which premium payment may be made.

Individual and Child(ren) Coverage. Means coverage that includes only the insured employee or member, as defined and eligible children as described in the certificate.

Individual and Spouse Coverage. Means coverage that includes only the insured employee or member, as defined, and his or her eligible spouse as described in the certificate.

Individual Coverage. Means coverage that includes only the insured employee or member, as defined.

Initial Enrollment Period. Means one of the following periods during which the employee or member may first apply in writing for coverage under this policy:

1. if the employee or member is eligible for coverage on the policy effective date, a period before the policy effective date as set by us and the policyholder; or
2. if the employee or member becomes eligible for coverage after the policy effective date, the period ending 31 days after the date he or she is first eligible to apply for coverage.

GLOSSARY (Continued)

Insured Employee or Member. Means the employee or member accepted for coverage by us who has completed and signed the enrollment form or evidence of insurability and whose name appears on the certificate specification page.

Member. Means a member in good standing in an labor union, association or other entity named as the policyholder and who is: (a) a citizen or resident of the United States; and (b) is (1) engaged in, or (2) able to engage in and currently seeking, active employment.

Policyholder. Means the legal entity to whom this policy is issued.

We, Us, and Our. Means American Heritage Life Insurance Company.

CERTIFICATE PROVISIONS MADE PART OF THIS GROUP POLICY

The remainder of this group policy consists of the provisions that will appear in the group certificate, including any optional riders or endorsements or amendments. The group certificate describes the insurance made available under this group policy to insured employees or members and their dependents, if applicable.

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AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

THIS IS A CRITICAL ILLNESS POLICY WHICH PROVIDES STATED BENEFITS FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED. THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

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A Stock Company

Endorsement

This Endorsement is made a part of the Group Policy to which it is attached. It is subject to all of the provisions, limitations and exclusions of the Group Policy not inconsistent with this Endorsement.

The CERTIFICATES OF INSURANCE provision in the GENERAL PROVISIONS section is deleted in its entirety and replaced with the following:

CERTIFICATES OF INSURANCE

We will furnish to the policyholder a certificate of insurance for delivery to each insured employee or member. The certificate will provide a description of the insurance provided by this policy and will state:

1. the essential features of the insurance coverage; and
2. to whom benefits are payable.

If there is any discrepancy between the provisions of any certificate and the provisions of this policy, the provisions of this policy govern.

All other requirements of the policy not specifically stated within this endorsement still apply.

Secretary

AMERICAN HERITAGE LIFE INSURANCE COMPANY
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A Stock Company

Endorsement

This Endorsement is made a part of the Certificate to which it is attached and is effective as of 04/01/14. It is subject to all of the provisions, limitations and exclusions of the Certificate not inconsistent with this Endorsement. This endorsement also applies to any riders attached to the Certificate, if applicable.

I. The CONTINUATION OF INSURANCE COVERAGE (COBRA) provision and the PORTABILITY PRIVILEGE provision are deleted in their entirety.

II. All references found throughout the certificate to the CONTINUATION OF INSURANCE COVERAGE (COBRA) provision and the PORTABILITY PRIVILEGE provisions are deleted in their entirety.

III. The CONTINUATION OF INSURANCE COVERAGE Provision is added as follows:

CONTINUATION OF INSURANCE COVERAGE

This section provides for automatic Continuation of Insurance Coverage, hereafter referred to as Continuation Coverage. It applies if a covered person suffers the loss of this group health insurance coverage due to one of the following events:

1. Termination of your employment; or your eligibility due to reduction in your hours; or the date you are no longer in an eligible class; or the date your class is no longer eligible. Insurance may be continued for any covered person.
2. Your death. Insurance may be continued for any covered person.
3. Divorce or legal separation. Insurance may be continued for any covered person whose insurance would otherwise end.
4. Your becoming eligible for Medicare. Insurance may be continued for any covered person who is not entitled to Medicare.
5. A child ceasing to be an eligible dependent as defined in the group policy. Insurance may continue for that child.
6. The policyholder filing a Chapter 11 Bankruptcy petition. Insurance may be continued for any insured retiree and his or her covered dependents. But this only applies if the insurance ends or is substantially reduced within 1 year before or after the filing of the bankruptcy.
7. Termination of the group policy. (Benefits will be determined as if the group policy had remained in full force and effect.)
8. Strike, layoff, leave of absence for personal reasons (not Family or Medical Leave Act (FMLA)). Insurance may be continued for any covered person.
9. Military Service. Your leave of absence due to military service. Insurance may be continued for any covered person, except for the person who is in active military service.

Continuation Coverage is not available for any person if coverage under the group policy terminated due to your failure to make required premium payments.

Continuation Coverage is not available to any person who is on FMLA. Continuation Coverage is also not available if a person fails to pay premium while on FMLA.

To be eligible for Continuation Coverage, a person must be insured under the group policy on the day before the event that caused loss of coverage. In the case of bankruptcy, the person must also be: (a) an employee or member who retired on or before the date insurance ends or is substantially reduced; or (b) a dependent of the retiree on the day before the bankruptcy.

A person will not be denied Continuation Coverage solely because he or she is covered under another group health plan like this one, or eligible for Medicare on the date of the event that caused loss of coverage.

COVERAGE CONTINUED

The Continuation Coverage may include any eligible dependents who were covered under the group policy. The coverage being continued is subject to all terms and provisions of the group policy that do not conflict with this section. The coverage will be the same as that provided under the group policy for other persons in the same insurance class in which such person would have been if the loss of coverage had not occurred. The coverage will be subject to any changes to the group policy affecting the benefits of such class. The coverage will be effective on the day after the insurance under the group policy terminates.

NOTIFICATION AND PAYMENT REQUIREMENTS

You or other qualifying dependents have the responsibility to inform the insurer of (a) divorce; (b) legal separation; or (c) a child losing eligibility under the policy. This notice must be made within 60 days of these events. Failure to provide this notification within 60 days will result in the loss of the right to continue the insurance.

The policyholder has the responsibility of notifying the insurer of (a) an insured's death, termination of employment, or reduction in hours; or (b) the policyholder's bankruptcy. This notice must be made within 30 days of the event.

The insurer will notify the qualifying person of the right to continue within 14 days of the notice described above.

The qualifying person will be required to pay a premium for the Continuation Coverage to the insurer.

PREMIUMS

Premiums are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The premium rate for the first 36 months of Continuation Coverage will not exceed 102% of the rate in effect under the group policy covering similarly situated class of employees who have not elected Continuation Coverage. After the first 36 months, the premium rate may change for the class of persons covered under Continuation Coverage. Written notice will be given at least 31 days before any change is to take effect.

GRACE PERIOD

The grace period, as defined in the group policy, will apply to each certificate holder of Continuation Coverage as if such insured is the policyholder.

TERMINATION OF INSURANCE

Insurance under Continuation Coverage will automatically end on the earliest of the following dates:

1. The date the person again becomes eligible for insurance under the group policy.
2. The last day for which premiums have been paid, if the insured fails to pay premiums when due, subject to the grace period.
3. With respect to insurance for dependents:
   a. the date your insurance terminates; or
   b. the date the dependent ceases to be an eligible dependent under the group policy.
4. The later of:
   a. the date you reach age 70; or
   b. 36 months after the date Continuation Coverage became effective.

A dependent child whose Continuation Coverage terminates when he or she reaches the age limit may apply for Continuation Coverage in his or her own name, if he or she is otherwise eligible.

Continuation Coverage will remain in effect for no longer than 36 months, or until you reach age 70, whichever occurs later.

All other requirements of the Certificate not specifically stated within this endorsement still apply.

Secretary

AMERICAN HERITAGE LIFE INSURANCE COMPANY

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A Stock Company

CERTIFICATE OF INSURANCE

This certificate of insurance ("certificate") describes your insurance coverage under the policy.

In this certificate, the words:

"You" and "your" mean the named insured employee or member shown on the Certificate Specifications page who is a member of an eligible class as described in the policy and for whom premiums are remitted.

"We", "us" and "our" mean American Heritage Life Insurance Company.

"This policy" and "the policy" mean the policy of insurance issued by us to the policyholder.

The policy alone makes up the agreement under which insurance coverage is provided and benefits are determined. If the terms of your certificate and the policy differ, the policy will govern. The policy may be inspected at the office of the policyholder during normal business hours.

Coverage under the policy is issued in consideration of your enrollment or other form of application and the payment of the first premium.

We certify that coverage under the policy is in effect for persons who have satisfied all eligibility requirements and for whom the required premium has been paid when due.

The policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

The policy and this certificate may be changed in whole or in part or cancelled by agreement between us and the policyholder. Such an action may be taken without the consent or notice to you or anyone covered under the policy. Only an authorized officer at our home office can approve a change. The approval must be in writing and endorsed on or attached to the policy. No other person, including an agent, may change the policy or certificate or waive any of its provisions. Premiums are subject to periodic changes.

This certificate supersedes and replaces any certificate previously issued to you under the policy.

Secretary

President

THIS IS A CRITICAL ILLNESS CERTIFICATE WHICH PROVIDES STATED BENEFITS ONLY FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED. THIS CERTIFICATE DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.

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GENERAL PROVISIONS

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l a e l a C e age l a a C e C e age e a a e e e age e e e e a e a age e a ge e e age l a a S e C e age a C e age a e a e a a e e l e a e e a e a age e e e e a e e e e e

l a e l a C e age l a a C e C e age e e a a e a e a e e e age e a e e e e a e a e e a e a e e a ge e e age l a a S e C e age a C e age a e a e a a e e l e a e e a e a e a e a e a e e e e a e e e

e e a e e l a a C e C e age a C e age e e e g e e age e age eg a e e a e e e a e e e a e e e e e e a a e e e e e a e l a a C e C e age a C e age e a e e e e e

l a e l a C e age l a a S e C e age e e a e a a e e e a e a l e e e e age a e a a a e e l a C e age l a a C e C e age l a a S e C e age a C e age a e a e a e e l a e e e e a a a e age e

a e e g a e e e a a g a l a a C e C e age a C e age e

C e age e a e e e a e e a e ee a a ee e e e a a e e a e

2 l a ee g a e ee e a a e e a e a e a e e a e age e e e

e e a e e age eg e a e e e a e e e 2 a e e a e e e e a e e e a e e e e a e a e e e e a e ee 2 a

C e age e e a g a a e e a e ee e a e e e a e e

TERMINATION OF COVERAGE

e age e e e ee a e
e a e e a e e
2 e a a e e a e e e a e e e a e
e a a a e a e e e e e a e e g a g e a
a a e e a e e e a e e e P V
S C I IC V S C
e a e a e ge a e g e a
e a e a ge e g e
e a e a e e e e e a a e e age e a e e a ea a e
e a a e a e e e a e e e a a a e e a e
e e e age a a a e a a e a e e e e e e e
I e a e e e e age e a e ee e ea
I e a e a e e e e a e e age e e a e e
a e ea
C e age a e e e e ea e e a e a e a e g e a e e
ge e g e e ea e e e a a e ea e age 22 2 a e e a e g
a e a a g e ea g e g e e e ee e e e e a
e g e e e e C e age e e a e a a e
a a e e a g e e ea e a a a a a
2 e a e a a a e e a a e e g age e g e e a
e e e e a a e a e
e e age e a g a e e a e e a e a e e a P
e a a a e e e e e e a e a a e e g age
e g e e a e e e a a e e e e e e a
a a a e e a a e e g age e g
I e a e a e e age e e g e e a e age e e e e a a a e e
e e e e e age e a e a e e a e e e e e e e
a e I a a C e C e age a C e age a e e a e e e g e e e e e e e
e
C e age a e e g e a a e e C I I I S C C e
P I I P IVI G

TEMPORARY LAYOFF LEAVE OF ABSENCE OR FAMILY AN ME ICAL LEAVE OF ABSENCE

I ea e a e e e e e e a a e a e a e a a ea e
a e e e e age e e e e age a a e e e e e a e e
e e a e e a e e a e ea e g C e age e
e g e a e ea e a e e e e e a a
I e age e e a a a e a ea e e e e age e e a e e e
a e a
e e e e e e a

LEGAL ACTION

ega a a e g a e e e e
a ea a a e a ee e
2 a e e e a ea e e e e e a e ee e

INCONTESTABILITY

e 2 ea e e e e a e e age a e e a e e e a e g a e e
e age e a a

CLERICAL ERROR

C e a e e a e e a a e a e e e e e a e
e e e a e e a e a a e e a e e e a e e a a a e
C e e e e e e e g a e a e

AGENCY

e e e e a e a a age e a e e
e e e ee e age

CONTINUATION OF INSURANCE (COBRA)

PP I S G PS I 2 P S S

e e a a a ae e e a a a e e l a e a e
e ee e e e g e e a e a a g e e

e a e e e a ea g e g e e
l a e a e e a a e e e e e e a e a e e e e e

2 ea l a e a e e a e e e e e e a e a e e e e e

e ega e a a l a e a e e a e e e e a e e e e C e e e a e age e a e a e e e e

e g e g e e a e l a e a e e a e e e e a e e e e a e e e e e a e e e e e

ea g e a e g e e e e a e e e e l a e a e e a

e e e a C a e a e l a e a e e a e e e e a e e e e e e a a e e a e e e a e e g a

e a a e a e e e e e e a e e a g e e l e a e a a e a e e e e e e a e e a e e a e e a a e e a a e e a e e e e a e e a e e e e e e a e a

e e e a e e a e a e e g a e a e g e e a e e a e g e e

COVERAGE CONTINUE

e a e e g e e e a e a e e a e e a g e e a e e e a e e e a e g e e a g e e a g e e

NOTIFICATION AN PAYMENT RE UIREMENTS

a e e e e e a e ega e a a a g e g e e e e a e a g e e a e e a a e e e g e e a e

e e a e e g e e a a a ea e a e e e e e e a e e a e a e g e e

e a a a e g e a e e e a e e a e a e e e e a e a a e a e a e e e a a e e a e g e a e

e e e a a e e e a e e a e e a e a a a a g a e e

CONTINUATION OF INSURANCE (COBRA) (C)

PP I S G PS I 2 P S S

TERMINATION

I a e e g e e e ae e e g ae a a
e ae e e ae a e e e ae e e a e e g e

2 e e e a e e age a e ee a e a e a e e
e a e e e a e e ae

e ae e e e e a e g a e e e a a e e ee
e e a e a a e a e e a e e g
e e a ae

e ae e e e e e e e ae a e a g e e e e e e
e ee e e e C a e a a e e e e

e ae e g e ae e a g e e e a e e a
e e e e e e e a e a g e e e
e e e age a a e e e e e a e e e e e e ae e
a g e e a e a g e e a e e ae e ae e g e ae
e a g e e e e a e e

a l ae a a e S a Se e a e g e a a e age
e e a e e e e 2 l e a a a e e
e e e e e e a a a e e e e e a
e e e e

a e S a Se e e a a a a
2 e a a e age

l a e a a g e e e a e e a a e e e e e a e
e e e ae a g e e e a e a e e e a e e a e e
e e a e a a e g e a e e

e a e e a e e e a e
2 e a e

a a g e e g e e e e e e C a e a a e
e e e e a e a e age

e e e e e e e
2 e e e e g e a e e e e e e a
a e e a e e a e e e e a e a e e a

e e a e e e a 2 e a e age e a a a e
e e a e a e a a e e a e e ll Vl e S a Se a e a e
e e a ge a e e e a e e a e e a a e a e
e e a a e eg g e a e a e e a

PORTABILITY PRIVILEGE

e e a e age e e e

S e age e a a a e e

e age e e e a e e e I I C V G a

2 e e e e a e e e a a e e e e a e age a e a a a e e a a

e e e a e a e

a e age e e a e e e a e e a e a e e e e a e

PORTABILITY COVERAGE

e e e e a e a e age e e a e a e e e e e e e e a e e a e P a e age a e a e g e e e e e e e e e a ge a e a e a e e a e e a e e e e a

P a e age e e e e e a a e a e e e e a e

PORTABILITY PREMIUMS

P e a e age a e e a a a e a a e a e e P e e a e a e e a e a e a e a e e a e e e e e e e a e e e e a a ge a e e a e e a e a e e a e a ge a e e e

GRACE PERIO

e g a e e a e e e a e a e e a e age a e e e e e

TERMINATION OF INSURANCE

I a e e a ege a a a e e e a e e g a e

e a e aga e e e g e a e e e

2 e a a e a e e e a a a e e e e g a e e

e e a e e e e a e a e e a e e e e a e e e e e a e e e a e e e e a e e

e e e e a e age e a e e e e a e e age a a a e age e a e e e e e g e

TERMINATION OF T E POLICY

I e e a e a e e e e e e g e e e e a e g e e e a e e e a e e e e e a e e e a e e e e e a e e e e e e a e age e e e e a e a e a e e e a e e

EXCLUSIONS

e a e e a a e a a e e e
a e a e e a e a a a e e e
2 l e a e e a
l ega a e a a a ega a
S e e a e e e e a e a a e a e e
S a e a e e a e a a g a e e e e a e
a e

(T .)

CRITICAL ILLNESS BENEFIT

GENERAL

S e e a a e e age e a a e e e a e e e ag e a a e e e e age

e a e ag e a e e e e e e e a

2 e a e e a e e

e e e a e e e a e e e a a e e e e e Se e C a l e e e a a e e e age

e e e a e e e e e e e e a e e e e e e a e ag ea a e a e e a a e a e a

C e age a e e e e a e e e e e e e g e a e e e

a a e e ag e a a e e Sa e Ca e e a g a e e a ag a e e e e a e e e a a e ge a a e e e e e e e e Sa e a e e e e a e e a a a e Sa e a e g e e e e e e e e Sa e

e a a e e a e e e

INITIAL CRITICAL ILLNESS BENEFIT

A. BENEFIT AMOUNT e e e a ea a a e e e e age e a a a e e e a e e a e Ce a e S e a age a a e e e e e

I C I	P B B A
ea a	
S e	
C a e Pa S ge	2
a ga a a	
S age e a a e	

B. BENEFIT ESCRIPTION. e a a e e a e

A . e ea a ea e a a e a e a e e e a a ea e ag e a e a e e a g a a ge a e e a a a e e e a a e g a a e a a e e a ag ea a a

ea a a e e a e a e a e e a a a

e a e ag ea a e a e ea a a e a e ea e

2 **S** e ea a e a g e g a e e a e g a a e e a g e a e a a e a a a e e e e e e e e a e e g a e

S e e e a e e a a l ea e e a a e e e e e e g a e

e a e ag S e e a e e e e a e e e e g a e a e ag g e

CRITICAL ILLNESS BENEFIT (C)

B. BENEFITS ESCRIPTION. (C)

C A B -P S . e g a ea e a g age e e a a e e a g a ea e a a g eg e e e e Sa e g g a e e e e e e ge e e e

C a a e a ge e e a a a a g a a e e e a e e a e e e e g a e e

e a e ag C a e Pa S ge e a e e a a a a e a ge

M O T . e g a a a a a ea g e a ea e e a a e ga e a a

e a e ag a ga a a e a e e a a ge e e e a a

E S R F . e e e e a e e e e e a e e e e g g e ea a e a

age e a a e e e e a a e a e a a a e e g g a a a

e a e ag S age e a a e e a e e a a eg e e e e e a e e e e e a

(T .)

OPTIONAL BENEFITS

SECON EVENT INITIAL CRITICAL ILLNESS BENEFIT

e a aSe e l a C a l e e e a e e e ag e a e e a a
a e a e e a e a e e l l l C l lC l SS l
e e a e ag e a 2 a e e a e ag e a a e a
2 e e a e ag e e e e e e e e
e e e a e a e e e a e a a a a e e e e a
e e e a Se e l a C a l e e e e ea a a e

(T .)

OPTIONAL BENEFITS

CANCER CRITICAL ILLNESS BENEFIT

A. BENEFIT AMOUNT e e e a ea a e a e e e e age e a a e a e e e a e e a e Ce a e S e a age a a e e e e e

C C I	P B B A
Ca a	2
I a e Ca e	

B. BENEFIT ESCRIPTION. e a e a e e a e

C I S . a e e e e e e e e g a g a e e g g e

Ca a e
a ea a e a e ag e a age I II e a e ag g a
e a a a g e e

Ca a e e
a e a g a e
e a g a e a ae e a e a a
e g

2 **I C .** a g a a a e e e e g a ea a g a e a e a e

I a e Ca e e e e a a a

I a e a e e e
a a a
e e e e a a e e
a e e a a e a g a e a a e e ee e a g a e a a e
e e e a a
ea a e age I II a e

C. IAGNOSIS RE UIREMENTS. a e a e e ag e e a

P ea e a a e a e a e e
e a a e e e e ag e e a e e a g e
ag a g a ee g e a a e e e a a Pa g

2 **C** ea a a e a a e a e a a a
e a e e a a ag
a a a g a ag a e a e e a e e a a a e e ea e g a
e e e a e e e e ag

e a e ag a e a e e a e e e e e a e a e a e
e ag a e a e

e ag a e e a ag a e e e a a e a a e ag e e e
e e e e a e e age a e e e ag a e e e a e ag e e e e e
e e e ee a a ea e e a e e 2 e e e a e
e e g e e e e a e e age a 2 e e e ea e

e e e ea e e e a e a e g e a e e
e e a e a e a e e

a e a e g e a ea g g a e a e a e e e e a a a
e g e g e e a a e e a ea e I ea e ea e e a e
e e e a e a e a a e a a e a e e

OPTIONAL BENEFITS

SUPPLEMENTAL CRITICAL ILLNESS II BENEFIT

A. BENEFIT AMOUNT e e e a ea e e a a e e e e age e a e e a a e e e a e e a e Ce a e S e a age a a e e e e e

S C I	P B B A
a e e e ea e	2
a e Pa ea e	2
e g a	
C a	
C e e e	
C e e ea g	
Pa a	

B. BENEFITS ESCRIPTION. e e e a a e e a e

A A . e e ea e a a e e e e e a a a e

e e ea e a g e ege e a e ea e e a a ag e a a e g a e e ea e

I a a a e ea a e e e ea e e e e a e e e e a a a g a e e a g a e e a a a g a e e a a a a e a e a e a ea e a e a g a e e S PP C I IC I SS I

B L e a e e a e e e ea e e e e e a ag e e e ea e ega e e e e e a a e e e e a e e age

a e ag a e e e ea e e a e a a ag e e e e e a a a a e e e e ea e

2 **A P . Pa** ea e a a e e e e e a a a e

Pa ea e a a e a ag e a a e g a Pa ea e

I a a a e ea a e Pa ea e e e e e a e 2 e e g a a e a e g e a e a a e e e e gg e a a e a e e a e e a a a a e a e a e a ea e a ea e a e a g a e e S PP C I IC I SS I

B L e a e e a e Pa ea e e e e e a ag e Pa ea e ega e e e e e a a e e e e e a e e age

a e ag a e Pa ea e e a e a a ag e e e e e a a a a e e Pa ea e

SUPPLEMENTAL CRITICAL ILLNESS II BENEFIT

B. BENEFITS ESCRIPTION. (C)

B B T . a e a
a e e e a a e g a e e e a g a e a a
a
e g e e e g a e g e ea g
a a e

e g a e e
a e
a a e a
ge a a

e a e ag e g a e a e a a e e e a e g a e e
a e e a a e g a e e a g a e a a

C . a e e a g e e e a e a
e g e a a a l a a e e e e e g a
e e e a ge a e e g g a e a e e a e ea e

C a e e a e a e a

e a e ag C a e a e e a a a a a e
e e a

C B . a e e e e e g e e e e a
a g
a g e e e e e e e a e e e a a e a e 2 2
e e a
a e e 2 eg ee e e e

e a e ag C e e e e a e a a g a e a a a e e a
e e e

C L . e a a e e e e a g e a

C e e e a g e e e a g a a e e e e e a e a g a
e e

e a e ag C e e e a g e a e e a g a e a a a e e a
a a e a e e a g

P . e a a e a e a e e 2 e

e a e ag Pa a e a e a a e a e e e ag a a a e a
a a a g a e e a e

C. ACTIVITIES OF AILY LIVING. e S PP C I IC I SS I
a e a g a e

a g a e e a a e ge a e a e e
2 e g a e e e e a g g a e a a e g a a a e
e g ge a e e a a a e a g e e
a e a e C e e a age e a a e e e
e ga e g a a a e a a ea a e e e ge e a a e
a e g e a a e a ee a e e e e
a g e a a ea a ee e a e a a e a a a e e e
a a e e

OPTIONAL BENEFITS

ELLNESS BENEFIT

e a e a e Ce a e S e a age e a e a ea e e e e a e e e a e e e e e e a e a e S e a age e a e a ea e e g e e e e e a e

a e a

2 e g e e a

e a e g a

C a e a ge e ea a e a

C 2 a e a ge 2 e a a a e a

C a e a ge e a e a

C e a a

C a

e ee g a a

e ee g e e a a a ea e a

a g a a

2 KG e a g a a

e e g a

e a a a

PV a Pa a Va a a

a e a e e a

a g a g ea a a

Pa S ea g P e Pa e a

PS a e e a ge e a e a e a

2 Se P e e e e e a a

2 S e e e ea a

22 e g a a

2 a ee g e a a a a a a a a e

(T .)

AIVER OF PREMIUM BENEFIT

e a e e e age e e e e e
e e a e e a a e a e e a a
2 e a a e a ea e e a
e e a e a e e e e e a a ea e e a e ea e a e
a e e ea e
e a e a e ge a e
2 2 ea e a a
e a e e age e a g e I I C V G
a e ea a e
a e a
2 g a a a e e a
e e a e a a e ea e a e e a e
a e ea
g e a a a e a e a e a e e e g e
a ega
2 g e e a a a e a e a a ga a a e e
e a a g e e e e
e e a a e e a e e e e e I e a a e e e
e e e a a ea e e e

(T .)

CLAIM INFORMATION

NOTICE OF CLAIM

e e age a a a a e a a a e a e a e a e
e e a e g e 2 a a e e e e e e a e e e e
e a a ea a e e g e e a e e a a
e a e age e e a e a 222 a a e age a e a
e a e e

e a a e e e e l e e e e a e e e e
a a e e a g e

FILING A CLAIM

e e a a a e e e a a e g e a e g a e a
e e e e a e e a e e

PROOF OF CLAIM

e e e a ea a e a a e l e g e
e e e e e e e e a a ea a g a e e a
a ea a e l a e e e e e e g e a e a ea e e e e
e a e ega a a a e

P YSICAL EXAMINATION AN AUTOPSY

e a e e g a e e e a e e a e a a g a e a a e
ea a e e e a a e g e a a e a a e e g e e e a
e e e a

PAYMENT OF CLAIMS

e e e g e a e e a e a a e e e e e a e a e a e
a e a a a ea a a e a e e e a e e e a e
e a e

l e e a e a a e e a e a e e a a a e e e a a e e a e e a a e e
e e e a e e e a a g e e e e e e e
e e e e a g e e e e a a e a e g a

OVERPAI CLAIM

e a e e g e e e a e a a e a e e a e e e a
e a e e a e e a e e a e a a e a e a e a e a e a e e a e

UNPAI PREMIUM

e a e a a e e a a e a e e e

CLAIM INFORMATION (C)

CLAIM REVIE

l a a e e e g e e e
e ea e a a
2 e a eae e e a a
g a a e e a a
g a a a a g a a ge e
a e e e a e a e a a e e a a ee e a e e e e

APPEALS PROCE URE

P g a a a a a e e a a a e e a a e a
e e e e a g a e e e e e e e a

(T .)

GLOSSARY

A E A E ea a e e e g e e e ea g
a a e a eg a a a e e e e g e a e a a a a e e eg a
a e e e

e g a ea e e a e e e g e C a e a

2 e ee e e a e e e a a e e e e e a
e e a e e e e e e g e e a

e e e e e
e e e a a e e

2 a a e a e e a e e e e e e
a a e e e e e a e

a a a e e a e e e e a a a a e e e a e
e a a e e e a e e e a a ea a e a e e e a g e

C Y ea a e e 2 e eg g a a ea ea a e g e e e
e a e ea

C P ea a e g
a e g e a e e g a e e e e e e a a a e a e
e age

2 a e g e a e e a e e e e a e e e e e a e
a e

C I ea e e a e e e e e C I IC I SS I a
e e a e a

P ea a e e e e a e e g e e age e a
a a e e e e a e e e a e a e a g e a
a e e e e

2 I a e e e e a e a e a e e e e a e e e
e a e a e e e a e a e e e e
I a e e e e a e a e a a e e a e a e e
e e e e e a e e e a e e a e e
e e a e
a a e e e ge e e a e e a e e e e a
e a ea ea age a
e e a ea e e e a e e e a
e e a e e a e a e e e e e a a a
g e a e e e a e e e e e a e a a
a a e a
e e ega a e e ega e a e a e e e a
e e a e e a a age e a a e a e a

I e e e a a e e a e e a e e g e age

E ea e a a a e e e e e e a e e e a e
a a a a e a e e e

GLOSSARY (C)

E I ea a a e e e e e a e e e e e e age e e a e e a e e e e e

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AMERICAN ERITAGE LIFE INSURANCE COMPANY
OME OFFICE
1776 AMERICAN ERITAGE LIFE RIVE
AC SONVILLE FLORI A 32224-6687
(904) 992-1776

A S C

T IS IS A CRITICAL ILLNESS CERTIFICATE IC PROVI ES STATE BENEFITS ONLY FOR SPECIFIE SIC NESSES AN IN URIES OR OT ER BENEFITS T AT MAY BE A E . T IS CERTIFICATE OES NOT PROVI E BENEFITS FOR ANY OT ER CON ITIONS.

AMERICAN ERITAGE LIFE INSURANCE COMPANY
OME OFFICE
1776 AMERICAN ERITAGE LIFE RIVE
AC SONVILLE FLORI A 32224-6687
(904) 992-1776

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Important Privacy Policy Notice

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Allstate
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NOTICE OF PRIVACY PRACTICES

T IS NOTICE ESCRIBES O ME ICAL INFORMATION ABOUT YOU MAY BE USE AN ISCLOSE AN O YOU CAN GET ACCESS TO T IS INFORMATION. PLEASE REVIE IT CAREFULLY.

<u>EFFECTIVE APRIL 14 2003</u>

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AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

GROUP CANCER AND SPECIFIED DISEASE INSURANCE POLICY
NON-PARTICIPATING

American Heritage Life Insurance Company (referred to as we, us, or our) will provide benefits under this policy. We make this promise subject to all of the provisions of this policy.

The policyholder should read this policy carefully and contact us promptly with any questions. This policy is delivered in and is governed by the laws of the governing jurisdiction, and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA), and consists of:

1. all policy provisions and any amendments and/or attachments issued; and
2. the policyholder's signed application.

This policy may be changed in whole or in part. The approval must be in writing, signed by one of our executive officers and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida on the policy effective date.

Secretary

President

THIS IS LIMITED BENEFIT CANCER AND SPECIFIED DISEASE COVERAGE
WHICH ONLY PROVIDES BENEFITS FOR CANCER
AND SPECIFIED DISEASES AS DEFINED AND
OTHER OPTIONAL BENEFITS
DESCRIBED HEREIN

TABLE OF CONTENTS

CANCER AND SPECIFIED DISEASE POLICY SPECIFICATIONS

POLICYHOLDER:	USD 262 VALLEY CENTER SCHOOL DISTRICT
POLICY NUMBER:	20216
POLICY EFFECTIVE DATE:	April 1, 2014
POLICY ANNIVERSARY DATE:	April 1, 2015 and the first day of April each calendar year thereafter.
GOVERNING JURISDICTION:	The state of Kansas and subject to the laws of that jurisdiction.

ELIGIBLE CLASS(ES): All classified and certified active employees working at least 20 hours per week excluding those who are insured under any other cancer or specified disease policy issued by American Heritage Life Insurance Company.

ELIGIBILITY WAITING PERIOD: None

BENEFITS: See page 3A

PLAN I - OPTIONAL BENEFIT(S):
Cancer Initial Diagnosis: $2,000.00
Intensive Care:
- Hospital Intensive Care Unit Confinement: N/A
- Step-Down Hospital Intensive Care Unit Confinement: N/A
- Ambulance: N/A

Wellness: $100.00/year

INITIAL RATE:
Monthly rate of $23.33 per employee for Individual Coverage; or
$36.15 per employee for Individual and Spouse Coverage; or
$32.51 per employee for Individual and Child(ren) Coverage; or
$45.31 per employee for Family Coverage

PLAN II - OPTIONAL BENEFIT(S):
Cancer Initial Diagnosis: $5,000.00
Intensive Care:
- Hospital Intensive Care Unit Confinement: N/A
- Step-Down Hospital Intensive Care Unit Confinement: N/A
- Ambulance: N/A

Wellness: $100.00/year

INITIAL RATE:
Monthly rate of $34.97 per employee for Individual Coverage; or
$54.12 per employee for Individual and Spouse Coverage; or
$49.48 per employee for Individual and Child(ren) Coverage; or
$68.61 per employee for Family Coverage

RATE GUARANTEE DATE: 04/01/2015

PREMIUM DUE: The initial date agreed to between American Heritage Life Insurance Company and the Policyholder and each specified date thereafter.

The policyholder must send all premiums on or before the premium due date to us. The premium must be paid in United States dollars.

COST OF COVERAGE: The employee pays the cost of coverage.

CANCER AND SPECIFIED DISEASE POLICY SPECIFICATIONS (Continued)

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES

These are the policyholder's divisions, subsidiaries, or affiliates listed below. The policyholder may act for and on behalf of any and all of these in all matters that pertain to this policy. Every act done by, agreement made with, or notice given to the policyholder will be binding on them.

Name	Location (City And State)
None	

CANCER AND SPECIFIED DISEASE POLICY – GVCP3KS

SEE BENEFITS SECTION OF POLICY FOR DETAILS OF BENEFITS

	PLAN I – BENEFITS	AMOUNT
A.	CONTINUOUS HOSPITAL CONFINEMENT	$200.00/DAY
B.	GOVERNMENT/CHARITY HOSPITAL	$200.00/DAY
C.	PRIVATE DUTY NURSING SERVICES	$200.00/DAY
D.	EXTENDED CARE FACILITY	$200.00/DAY
E.	AT HOME NURSING	$200.00/DAY
F.	HOSPICE CARE	
	1. FREESTANDING HOSPICE CARE CENTER	$200.00/DAY
	2. HOSPICE CARE TEAM	$200.00/VISIT
G.	RADIATION/CHEMOTHERAPY FOR CANCER	UP TO $10,000.00/12 MONTHS
H.	BLOOD, PLASMA AND PLATELETS	UP TO $10,000.00/12 MONTHS
I.	HEMATOLOGICAL DRUGS	UP TO $200.00/YEAR
J.	MEDICAL IMAGING	UP TO $500.00/YEAR
K.	SURGERY	UP TO $1,500.00 PER UNIT OF COVERAGE SEE SCHEDULE OF SURGICAL PROCEDURES 2 UNITS OF COVERAGE
L.	ANESTHESIA	25% OF SURGERY BENEFIT
M.	BONE MARROW OR STEM CELL TRANSPLANT	
	1. AUTOLOGOUS TRANSPLANT	$1,000.00/YEAR
	2. NON-AUTOLOGOUS TRANSPLANT	$2,500.00/YEAR
	3. NON-AUTOLOGOUS TRANSPLANT FOR THE TREATMENT OF LEUKEMIA	$5,000.00/YEAR
N.	AMBULATORY SURGICAL CENTER	$500.00/DAY
O.	SECOND OPINION	$400.00
P.	INPATIENT DRUGS AND MEDICINE	$25.00/DAY
Q.	PHYSICIAN'S ATTENDANCE	$50.00/DAY
R.	AMBULANCE	$100.00/CONFINEMENT
S.	NON-LOCAL TRANSPORTATION	COACH FARE OR $0.40/MILE
T.	OUTPATIENT LODGING	$50.00/DAY $2,000.00/12 MONTHS
U.	FAMILY MEMBER LODGING AND TRANSPORTATION	$50.00/DAY COACH FARE OR $0.40/MILE
V.	PHYSICAL OR SPEECH THERAPY	$50.00/DAY
W.	NEW OR EXPERIMENTAL TREATMENT	UP TO $5,000.00/12 MONTHS

PLAN I – BENEFITS (Continued)	**AMOUNT**
X. PROSTHESIS/BREAST RECONSTRUCTION	
1. PROSTHESIS	UP TO $2,000/AMPUTATION
2. BREAST RECONSTRUCTION	UP TO $1,200.00
Y. HAIR PROSTHESIS	$25.00/2 YEARS
Z. NONSURGICAL EXTERNAL BREAST PROSTHESIS	$50.00/INITIAL PROSTHESIS
AA. ANTI-NAUSEA	$200.00/YEAR
BB. WAIVER OF PREMIUM	AFTER 90 DAYS

CANCER AND SPECIFIED DISEASE POLICY – GVCP3KS

SEE BENEFITS SECTION OF POLICY FOR DETAILS OF BENEFITS

	PLAN II – BENEFITS	AMOUNT
A.	CONTINUOUS HOSPITAL CONFINEMENT	$300.00/DAY
B.	GOVERNMENT/CHARITY HOSPITAL	$300.00/DAY
C.	PRIVATE DUTY NURSING SERVICES	$300.00/DAY
D.	EXTENDED CARE FACILITY	$300.00/DAY
E.	AT HOME NURSING	$300.00/DAY
F.	HOSPICE CARE	
	1. FREESTANDING HOSPICE CARE CENTER	$300.00/DAY
	2. HOSPICE CARE TEAM	$300.00/VISIT
G.	RADIATION/CHEMOTHERAPY FOR CANCER	UP TO $15,000.00/12 MONTHS
H.	BLOOD, PLASMA AND PLATELETS	UP TO $15,000.00/12 MONTHS
I.	HEMATOLOGICAL DRUGS	UP TO $300.00/YEAR
J.	MEDICAL IMAGING	UP TO $750.00/YEAR
K.	SURGERY	UP TO $1,500.00 PER UNIT OF COVERAGE SEE SCHEDULE OF SURGICAL PROCEDURES 3 UNITS OF COVERAGE
L.	ANESTHESIA	25% OF SURGERY BENEFIT
M.	BONE MARROW OR STEM CELL TRANSPLANT	
	1. AUTOLOGOUS TRANSPLANT	$1,500.00/YEAR
	2. NON-AUTOLOGOUS TRANSPLANT	$3,750.00/YEAR
	3. NON-AUTOLOGOUS TRANSPLANT FOR THE TREATMENT OF LEUKEMIA	$7,500.00/YEAR
N.	AMBULATORY SURGICAL CENTER	$750.00/DAY
O.	SECOND OPINION	$600.00
P.	INPATIENT DRUGS AND MEDICINE	$25.00/DAY
Q.	PHYSICIAN'S ATTENDANCE	$50.00/DAY
R.	AMBULANCE	$100.00/CONFINEMENT
S.	NON-LOCAL TRANSPORTATION	COACH FARE OR $0.40/MILE
T.	OUTPATIENT LODGING	$50.00/DAY $2,000.00/12 MONTHS
U.	FAMILY MEMBER LODGING AND TRANSPORTATION	$50.00/DAY COACH FARE OR $0.40/MILE
V.	PHYSICAL OR SPEECH THERAPY	$50.00/DAY
W.	NEW OR EXPERIMENTAL TREATMENT	UP TO $5,000.00/12 MONTHS

PLAN II – BENEFITS (Continued)	**AMOUNT**
X. PROSTHESIS/BREAST RECONSTRUCTION	
1. PROSTHESIS	UP TO $2,000/AMPUTATION
2. BREAST RECONSTRUCTION	UP TO $1,200.00
Y. HAIR PROSTHESIS	$25.00/2 YEARS
Z. NONSURGICAL EXTERNAL BREAST PROSTHESIS	$50.00/INITIAL PROSTHESIS
AA. ANTI-NAUSEA	$200.00/YEAR
BB. WAIVER OF PREMIUM	AFTER 90 DAYS

POLICYHOLDER PROVISIONS

RATE GUARANTEE

A change in premium rate will not take effect before the Rate Guarantee Date shown on page 3 except for reasons which affect the risk assumed, including those reasons shown below:

1. a change occurs in this plan design; or
2. a division, subsidiary, or affiliated company is added or deleted; or
3. the number of insureds changes by 20% or more; or
4. a new law or a change in any existing law is enacted which applies to this plan; or
5. less than 20% of those eligible for coverage are participating.

We will notify the policyholder in writing at least 30 days before a premium rate is changed. A change may take effect on an earlier date when both we and the policyholder agree in writing.

PREMIUM INCREASES OR DECREASES

Premium increases or decreases may take effect any time subject to the Rate Guarantee provision. If they take effect during a policy month, they are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

INFORMATION REQUIRED FROM THE POLICYHOLDER

The policyholder must provide us with the following on a regular basis:

1. information about employees or members:
    a. who are eligible to become insured; and
    b. whose coverage changes; and
    c. whose coverage ends; and
2. any information that may be required to manage a claim; and
3. any other information that may be reasonably required.

Policyholder records that have a bearing, in our opinion, on this policy will be available for review by us at any reasonable time.

CANCELING POLICY

This policy can be canceled:

1. by us; or
2. by the policyholder.

We may cancel or offer to modify this policy, with at least 31 days written notice to the policyholder, if:

1. less than 20% of those eligible for coverage are participating; or
2. this policy has been in effect more than 12 months; or
3. the policyholder does not promptly provide us with information that is reasonably required; or
4. the policyholder fails to perform any of its obligations that relate to this policy; or
5. fewer than 20% employees or members are insured; or
6. the policyholder fails to pay any premium within the 31 day grace period.

If the premium is not paid during the grace period, this policy will terminate automatically at the end of the grace period. The policyholder is liable for the premium for coverage during the grace period. The policyholder must pay us all premiums due for the full period this policy is in force.

The policyholder may cancel this policy by written notice delivered to us at least 31 days prior to the cancellation date. When both the policyholder and we agree, this policy can be canceled on an earlier date. If canceled, coverage will end at 12:00 midnight on the last day of coverage.

If this policy is canceled, the cancellation will not affect a payable claim incurred prior to cancellation.

GENERAL PROVISIONS

ELIGIBILITY OF DEPENDENTS

Eligible dependents are:

1. the employee's or member's legal spouse or domestic partner; and
2. unmarried children of the employee or member including adopted children from the moment of placement in the residence, stepchildren, children of a domestic partner or legal ward who are under 22 years old, or under 26 years old and full-time students at an educational institution of higher learning beyond high school. The employee's or member's children must be dependent on the employee or member for support or reside with the employee or member over 50% of the time in a regular parent-child relationship and be named on the enrollment or evidence of insurability form.

After the effective date, any person (except newborns, who are covered from the moment of birth) who becomes an eligible dependent can be added to this policy if we are notified within 31 days after they become eligible.

If the insured employee or member has Individual Coverage or Individual and Child(ren) Coverage, then marries and desires coverage for his or her spouse, we must be notified within 31 days of the marriage. We will change the coverage to Individual and Spouse Coverage or Family Coverage and provide notification of the additional premium due. If we are not notified within 31 days of the marriage, then evidence of insurability will be required for the spouse.

If the insured employee or member has Individual Coverage or Individual and Child(ren) Coverage, then establishes a domestic partnership and desires coverage for his or her domestic partner, we must be notified within 31 days of the date the domestic partnership was formed. We will change the coverage to Individual and Spouse Coverage or Family Coverage and provide notification of the additional premium due. If we are not notified within 31 days of the date a domestic partnership was formed, then evidence of insurability will be required.

A child born to the insured employee or member or spouse or domestic partner, while Individual and Child(ren) Coverage or Family Coverage is in force, will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for any other person covered under this policy. No additional premium will be required for newborns added if Individual and Child(ren) Coverage or Family Coverage is in force at the time the newborn is added.

If the insured employee or member has Individual Coverage or Individual and Spouse Coverage, newborn children are automatically covered from the moment of birth for a period of 31 days. If the insured employee or member desires uninterrupted coverage for a newborn child, the insured employee or member must notify us within 31 days of that child's birth. Upon notification, we will convert the insured employee's or member's Individual Coverage to Individual and Child(ren) Coverage or Individual and Spouse Coverage to Family Coverage and provide notification of additional premium due. If the insured employee or member does not notify us within 31 days of the birth of the child, the temporary automatic coverage ends.

An adopted child or child pending adoption will be covered as follows, as long as Individual and Child(ren) Coverage or Family Coverage is in force:

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by the insured employee or member has been entered within 31 days after the date of birth.
2. If adoption proceedings have been instituted by the insured employee or member within 31 days after the date of birth and the insured employee or member has temporary custody, coverage is provided from the moment of birth.
3. For children other than newborns, if adoption proceedings have been completed, and a decree of adoption was entered within 1 year from the institution of the proceedings, coverage will begin upon temporary custody for 1 year, unless extended by the order of the court by reasons of the special needs of the child.

Coverage must be provided as long as the insured employee or member has custody of the child pursuant to decree of the court and required premiums are paid.

ELIGIBILITY DATE

If the employee is working for the employer in an eligible class or if a person is a member of the policyholder's union or association, the date such employee or member is eligible for coverage is the later of:

1. this policy's effective date; or
2. the date such person becomes a member of the eligible class and completes any applicable eligibility waiting period.

GENERAL PROVISIONS (Continued)

WHEN AN ELIGIBLE EMPLOYEE OR MEMBER CAN ENROLL, CHANGE OR DISCONTINUE COVERAGE

1. The employee or member may apply for coverage during:
   a. his or her initial enrollment period; or
   b. at any other time, subject to evidence of insurability.
2. The employee or member may increase coverage at any time, subject to evidence of insurability**.**
3. The employee or member may discontinue coverage at any time.

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required if:
1. the employee or member:
   a. voluntarily canceled coverage and is reapplying; or
   b. is applying for the coverage, or an increase in the amount of coverage, at any time after his or her initial enrollment period.
2. an eligible dependent did not enroll within 31 days of eligibility.

EFFECTIVE DATE OF COVERAGE

Coverage for each eligible employee or member is effective at 12:01 a.m. on the effective date shown on the certificate of insurance issued to that person.

For any change in an insured employee's or member's coverage that is subject to evidence of insurability, the change in coverage is effective on the date we approve such change.

For any change in coverage that is not subject to evidence of insurability, the change in coverage is effective on the date we receive such request for change.

WHEN AN EMPLOYEE IS ABSENT FROM WORK OR A MEMBER IS NOT ENGAGED IN ACTIVE EMPLOYMENT ON THE EFFECTIVE DATE OF COVERAGE

If an employee or member is absent from work due to disability, injury, sickness, temporary layoff, leave of absence or Family and Medical Leave of Absence, coverage for that person begins on the date they meet the definition of active employment. This applies to such person's initial coverage, as well as any increase or addition to coverage that occurs after such person's initial coverage is effective.

CERTIFICATES OF INSURANCE

We will issue certificates of insurance for each insured employee or member. The certificate will provide a description of the insurance provided by this policy and will state:
1. the benefits provided; and
2. to whom benefits are payable; and
3. the limitations, exclusions and requirements that apply to coverage under this policy.

If there is any discrepancy between the provisions of any certificate and the provisions of this policy, the provisions of this policy govern.

GENERAL PROVISIONS (Continued)

TERMINATION OF COVERAGE

The insured employee's or member's coverage under the certificate ends on the earliest of:
1. the date this policy is canceled; or
2. the last day of the period for which such employee made any required premium payments; or
3. the last day such insured employee or member is in active employment or membership, except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision; or
4. the date such insured employee or member is no longer in an eligible class; or
5. the date such insured employee's or member's class is no longer eligible.

We will provide coverage for a payable claim incurred while the insured employee or member is covered under this policy.

If the insured employee's or member's spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or death of the insured employee or member.

If the insured employee's or member's domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or death of the insured employee or member.

Coverage for a dependent child ends on the certificate anniversary next following the date the child is no longer eligible This is the earlier of: (a) when the child marries; or (b) reaches age 22 (26 if a full-time student attending an educational institution of higher learning beyond high school); or (c) otherwise does not meet the requirements of an eligible dependent. Coverage does not terminate on an unmarried child who:
1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under this policy; and
3. is chiefly dependent upon the insured employee or member for support and maintenance.

The child's coverage continues as long as the insured employee's or member's coverage remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished within 60 days of the child's attainment of the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims will not be paid. There may be no refund due if the insured employee or member has Individual and Child(ren) Coverage or Family Coverage and there are other eligible dependents covered under this policy.

AGENCY

For purposes of this policy, this policyholder acts on its own behalf or as the employee's or member's agent. Under no circumstances will the policyholder be deemed our agent.

TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE

If an insured employee or member ceases active employment or terminates membership because of a temporary layoff or leave of absence while coverage is in force, we will continue the insured employee's or member's coverage in accordance with the personnel practices of the policyholder, if premium payments continue and the policyholder approved the leave in writing. Coverage will be continued for 3 months following the date the insured employee or member ceases active employment or membership.

If the insured employee's or member's coverage ends while on a Family and Medical Leave of Absence, his or her coverage will be reinstated when he or she returns to active status.

We will not:

1. apply a new pre-existing conditions limitation ; or
2. require evidence of insurability**.**

GENERAL PROVISIONS (Continued)

ENTIRE CONTRACT

The contract consists of the following items:
1. the group policy; and
2. any amendments and endorsements; and
3. the applications and other written statements of the policyholder; and
4. any individual applications, enrollments, evidence of insurability or other statements of the insured employee.

Any statements made by the policyholder or by a covered person, in the absence of fraud, are representations and not warranties. Only written statements signed by the policyholder or a covered person will be used in defense of a claim. A copy of any written statement, if applicable, will be furnished to the policyholder or the covered person or his or her personal representative, if any, if such written statement will be used in defense of a claim.

INCONTESTABILITY

After 2 years from the effective date of this policy, no misstatement of the policyholder, made in any applications, can be used to void this policy. After 2 years from the effective date of coverage, no misstatement of a covered person, made in writing, can be used to void coverage or deny a claim.

LEGAL ACTION

No legal action may be brought to obtain benefits under this policy:
1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 5 years from the time written proof of loss is required to have been furnished.

CLERICAL ERROR

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by the policyholder documenting any clerical errors.

UNPAID PREMIUM

Upon the payment of a claim under this policy, any unpaid premium may be deducted.

EFFECT OF PRIOR COVERAGE ON LOSSES FOR PRE-EXISTING CONDITIONS

We may pay benefits if an insured employee's or member's claim results from a pre-existing condition if he or she was:
1. in active employment and insured under this plan on its effective date; and
2. insured by the prior group policy when it terminated.

The coverage that was provided under the prior group policy must be substantially similar to this plan and have been in effect within 60 days of this plan's effective date in order for this provision to apply.

In order to receive benefits the insured employee or member must satisfy the pre-existing condition provision under:
a. the American Heritage Life plan; or
b. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If item a. or b. above is not satisfied, we will not pay any benefits resulting from a pre-existing condition.

If item a. is satisfied, we will determine our payment according to our policy provisions.

IF AN INSURED EMPLOYEE OR MEMBER HAS A LOSS DUE TO A PRE-EXISTING CONDITION AND CHANGES FROM INDIVIDUAL INSURANCE THROUGH AMERICAN HERITAGE LIFE TO GROUP INSURANCE THROUGH AMERICAN HERITAGE LIFE

We may pay benefits if an insured employee's or member's loss results from a pre-existing condition if the insured employee or member was:

1. in active employment and insured under this plan on its effective date; and
2. insured by the prior individual insurance policy with American Heritage Life when it terminated.

The coverage that was provided under the prior individual policy must be substantially similar to this plan and have been in effect within 60 days of this plan's effective date in order for this provision to apply.

In order to receive benefits, the insured employee or member must satisfy the pre-existing condition provision under:

a. the American Heritage Life plan; or
b. the prior individual insurance policy through American Heritage Life, if benefits would have been paid had the policy remained in force.

If item a. or b. above is not satisfied, we will not pay any benefits resulting from a pre-existing condition.

If item a. or b. is satisfied, we will determine our payments according to our policy provisions.

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CONTINUATION OF INSURANCE (COBRA)

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES OR MEMBERS)

This section provides for continuation as mandated by federal law for all benefits. It applies if a covered person's insurance would otherwise end due to one of the following events, called a qualifying event.

1. Termination of employment (other than by reason of gross misconduct), or of an insured employee's or member's eligibility due to reduction in his or her hours. Insurance may be continued for any covered person, except for domestic partners and their covered dependents.
2. The death of an insured employee or member. Insurance may be continued for any covered person, except for domestic partners and their covered dependents.
3. Divorce or legal separation. Insurance may be continued for a covered spouse whose insurance would otherwise end. However, COBRA does not extend continuation of coverage to domestic partners and their dependents).
4. The insured employee or member becoming eligible for Medicare. Insurance may be continued for any covered dependents who are not entitled to Medicare, except for domestic partners and their covered dependents.
5. A child ceasing to be an eligible dependent as defined in this policy. Insurance may be continued for that child.
6. The policyholder files a Chapter 11 Bankruptcy petition. Insurance may be continued for any insured retiree and his or her covered dependents. But this only applies if the insurance ends or is substantially reduced within 1 year before or after the filing for bankruptcy.

To choose this continuation of insurance, a person must be insured under this policy on the day before the qualifying event. In the case of bankruptcy, the person must also be: (a) an employee or member who retired on or before the date insurance ends or is substantially reduced; or (b) a dependent of the retiree on the day before the bankruptcy.

A person will not be denied continuation solely because he or she is covered under another group cancer and specified disease policy or eligible for Medicare on the date the qualifying event occurs.

COVERAGE CONTINUED

The insurance being continued is subject to all terms and provisions of this policy that do not conflict with this section. The insurance will be the same as that provided under this policy for other persons in the same insurance class in which such person would have been if the qualifying event had not occurred. The continued insurance will be subject to any changes to this policy affecting the benefits of such class following the qualifying event.

NOTIFICATION AND PAYMENT REQUIREMENTS

The insured employee or member or other qualifying dependents have the responsibility to inform the policyholder of: (a) divorce; (b) legal separation; or (c) a child losing eligibility under this policy. This notice must be made within 60 days of the qualifying event. Failure to provide this notification within 60 days will result in the loss of the right to continue the insurance.

The policyholder has the responsibility of notifying the plan administrator of: (a) an insured employee's or member's death, termination of employment, or reduction in hours; or (b) the policyholder's bankruptcy. This notice must be made within 30 days of the qualifying event.

The plan administrator will notify the qualifying person of the right to continue within 14 days of the notice described above. The person will then have 60 days to elect to continue his or her insurance. Failure to elect to continue insurance within 60 days after a person is notified by the plan administrator will result in loss of the right to continue such insurance.

The qualifying person will be required to pay a premium for the continued insurance to the policyholder. He or she will have 45 days from the date of election to pay the initial premium due. All further premiums will be due on a monthly basis with a 31 day grace period.

CONTINUATION OF INSURANCE (COBRA) – (Continued)

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES OR MEMBERS)

TERMINATION

Insurance being continued will terminate on the first of the following dates that apply:

1. The date this policy terminates or is amended to terminate the type of insurance being continued.
2. The end of the last period for which premiums for such coverage has been made. This applies if any required premium is not made to the policyholder within 31 days of the due date.
3. The date the person becomes covered under any other group cancer policy, whether as an insured or otherwise. (This will not apply if such other policy contains any exclusion or limitation with respect to any pre-existing condition the person may have.)
4. The date the person becomes entitled to benefits under Medicare. (This will not apply if the qualifying event involves retired employees or members of policyholders under Chapter 11 Bankruptcy and his or her dependents.)
5. The date ending 18 months from the date of the qualifying event for persons who qualify due to termination of employment or reduction in hours worked. However, if a second qualifying event occurs within this 18 month period, the period of coverage for any affected dependent may be extended up to 36 months from the date of the first qualifying event. For all other qualifying events, insurance will terminate on the date ending 36 months from the date of the qualifying event, except as provided below:
   a. If a person is totally disabled for Social Security purposes any time during the first 60 days of continuation coverage, the 18 month period may be extended to 29 months. In order for this additional 11 months of insurance to be effective, the covered person must provide the policyholder or plan administrator with a copy of the notice of the determination. The notice must be provided:
      1. within 60 days of the Social Security determination of total disability; and
      2. within the initial 18 months of continuation coverage.
   b. If an insured employee or member has a qualifying event (termination or reduction in hours worked) and he or she had become entitled to Medicare before the date of this qualifying event, then any other qualified beneficiary (the spouse and/or children) will be entitled to a period of continuation that is the greater of:
      1. 36 months from the date the insured employee or member first became entitled to Medicare; or
      2. 18 months from the insured employee's or member's termination or reduction in hours.
   c. For a qualifying event involving retired employees or members of policyholders under Chapter 11 Bankruptcy and his or her dependents, the maximum period of continuation coverage is:
      1. the lifetime of the retiree; or
      2. the lifetime of the surviving spouse of a retiree who dies before the bankruptcy; or
      3. 36 months after the date of death of the retiree, when such date is after the bankruptcy.
6. With respect to a person entitled to a 29 month period of continuation coverage due to disability of a qualified beneficiary, the date of a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled. However, insurance will not terminate until the last day of the month that next follows the completion of a 30 day period beginning on the date of such final determination.

PORTABILITY PRIVILEGE

We will provide portability coverage, subject to these provisions.

Such coverage will not be available for a covered person, unless:

1. coverage under this policy terminates under the General Provision entitled "Termination of Coverage"; and
2. we receive a written request and payment of the first premiums for the portability coverage not later than 30 days after such termination; and
3. a request is made for that purpose.

No portability coverage will be provided for any person, if his or her insurance under this policy terminated due to his or her failure to make required premium payments.

PORTABILITY COVERAGE

The benefits, terms and conditions of the portability coverage will be the same as those provided under this policy when the insurance terminated. Portability coverage may include any eligible dependents who were covered under this policy. Any change made to this policy after a person is insured under the portability privilege will not apply to that covered person unless it is required by law.

Portability coverage will be effective on the day after insurance under this policy terminates.

PORTABILITY PREMIUMS

Premiums for portability coverage are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The portability premium rate is the rate in effect under this policy for active employees who have the same coverage. The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least 31 days before the change is to take effect.

GRACE PERIOD

The grace period, as defined in this policy, will apply to each certificate holder of portability coverage as if such covered person is the policyholder.

TERMINATION OF INSURANCE

Insurance under this portability privilege will automatically end on the earliest of the following dates:

1. the date the person again becomes eligible for insurance under this policy; or
2. the last day for which premiums have been paid, if the covered person fails to pay premiums when due, subject to the grace period; or
3. with respect to insurance for dependents:
   a. the date the employee's or member's insurance terminates; or
   b. the date the dependent ceases to be an eligible dependent, as defined.

A dependent child whose portability coverage terminates when he or she reaches the age limit may apply for portability coverage in his or her own name, if he or she is otherwise eligible.

TERMINATION OF THE POLICY

If this policy terminates, insured employees or members and their covered dependents will be eligible to exercise the portability privilege on the termination date of this policy. Portability coverage may continue beyond the termination date of this policy, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if the policy had remained in full force and effect.

LIMITATIONS / EXCEPTIONS

1. PRE-EXISTING CONDITION LIMITATION

We do not pay for any benefit due to, or caused by, a pre-existing condition, as defined, during the 12 month period beginning on the date that person became a covered person.

2. OTHER LIMITATIONS AND EXCEPTIONS

We do not pay for any loss except for losses due directly from cancer or a specified disease. We do not pay for any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim.

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BENEFIT INFORMATION

PAYMENT OF BENEFITS

If cancer or a specified disease is diagnosed on or after the covered person's effective date, we pay according to the benefits provisions in this policy, subject to the Limitations/Exceptions provision and all other provisions contained in this policy.

If diagnosis is made while the covered person is hospital confined, benefits begin retroactively to the day of admission or 10 days prior to the date of diagnosis if this is more favorable.

If positive diagnosis is made within 12 months after a tentative diagnosis, benefits are paid from the date of tentative diagnosis if the tentative diagnosis is made on or after the effective date, subject to the Pre-existing Condition Limitation provision.

If a covered person dies while an inpatient in a hospital and cancer or a specified disease is not diagnosed until after the covered person's death, benefits will begin retroactively to the day of admission, up to a maximum of 30 days prior to death.

SCHEDULE OF BENEFITS

We pay the following benefits for the necessary services and products for a covered cancer or a specified disease. Treatment must be received in the United States or its territories.

For those benefits for which we pay actual charges up to a specified maximum amount, benefits K., W. and X., if specific charges are not obtainable as proof of loss, we will pay 50% of the applicable maximum for the benefits payable.

No benefits are payable for the treatment of cancer or a specified disease except those expressly stated in this Schedule of Benefits.

A. Continuous Hospital Confinement. If a covered person is admitted to and confined as an inpatient in a hospital, we pay the amount shown on page 3A per day for each day.

B. Government or Charity Hospital. In lieu of all other benefits in this policy (except the Waiver of Premium benefit), we pay the amount shown on page 3A per day for each day a covered person is confined to: (1) a hospital operated by or for the U.S. Government (including the Veteran's Administration); or (2) a hospital that does not charge for the services it provides (charity).

C. Private Duty Nursing Services. While a covered person is an inpatient receiving treatment, we pay the amount shown on page 3A per day if such covered person requires the full-time services of a private nurse. Full-time means at least 8 hours of attendance during a 24 hour period. These services must be required and authorized by the attending physician and must be provided by a nurse.

D. Extended Care Facility. We pay the amount shown on page 3A per day for each day a covered person is confined in an extended care facility. Confinement in the extended care facility must be at the direction of the attending physician and must begin within 14 days after a covered hospital confinement. This benefit is limited to the number of days of the previous continuous hospital confinement.

E. At Home Nursing. While a covered person is receiving treatment, we pay the amount shown on page 3A per day for private nursing care and attendance by a nurse at home. At home nursing services must be required and authorized by the attending physician. This benefit is limited to the number of days of the previous continuous hospital confinement.

F. Hospice Care. When a covered person is:
1. determined by a physician to be terminally ill; and
2. expected to live 6 months or less;

we pay one of the following two benefits for hospice care:

a. Freestanding Hospice Care Center. We pay the amount shown on page 3A per day for confinement in a licensed freestanding hospice care center. The covered person must be diagnosed by a physician as terminally ill and the attending physician must approve the confinement. This benefit is payable only if a covered person is admitted to a freestanding hospice care center. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or

b. Hospice Care Team. We pay the amount shown on page 3A per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. This benefit is payable only if: (1) the covered person has been diagnosed as terminally ill; and (2) the attending physician has approved such services. We do not pay for: (a) food services or meals other than dietary counseling; or (b) services related to well-baby care; or (c) services provided by volunteers; or (d) support for the family after the death of the covered person.

G. Radiation/Chemotherapy for Cancer. We pay the actual cost, up to the amount stated below for radiation therapy and chemotherapy received by a covered person.

This benefit is limited to the amount shown on page 3A per 12 month period beginning with the first day of benefit under this provision. Administration of radiation therapy or chemotherapy other than by medical personnel in a physician's office or hospital, including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12 month period explained above.

We only pay this benefit for cancer treatment consisting of:
1. cancericidal chemical substances for the purpose of modification or destruction of cancer or a specified disease; and
2. X-ray radiation; and
3. radium and cesium implants; and
4. cobalt.

This benefit does not pay for: (a) any other chemical substance which may be administered with or in conjunction with radiation/chemotherapy; or (b) treatment planning; or treatment consultation; or treatment management; or the design and construction of treatment devices; or basic radiation dosimetry calculation; or any type of laboratory tests; or X-ray or other imaging used for diagnosis or disease monitoring; or the diagnostic tests related to these treatments; or (c) any devices or supplies including intravenous solutions and needles related to these treatments.

H. Blood, Plasma and Platelets. We pay the actual cost, up to the limit stated below, when a covered person receives:
1. blood, plasma and platelets (including transfusions and administration charges); and
2. processing and procurement costs; and
3. cross-matching.

This benefit is limited to the amount shown on page 3A per 12 month period beginning with the first day of benefit under this provision. We do not pay for blood replaced by donors. We also do not pay for immunoglobulins.

I. Hematological Drugs. We pay the actual cost up to the amount shown on page 3A for drugs intended to boost cell lines such as white blood cell counts, red blood cell counts and platelets. This benefit is paid only when the Radiation/Chemotherapy for Cancer benefit (benefit G.) is paid.

J. Medical Imaging. We pay the actual cost once per calendar year, up to the amount shown on page 3A if a covered person receives an initial diagnosis or follow-up evaluation based upon one of the following medical imaging exams: CT scan; Magnetic Resonance Imaging (MRI) scan; bone scan; thyroid scan; Multiple Gated Acquisition (MUGA) scan; Positron Emission Tomography (PET) scan; transrectal ultrasound; or abdominal ultrasound. This benefit is limited to 1 payment per calendar year per covered person.

K. Surgery. We pay the actual charges, up to the amount listed in the Schedule of Surgical Procedures for the specific procedure per unit of coverage shown on page 3A when surgery is performed on a covered person:
1. for the purpose of treating a diagnosed cancer or specified disease; or
2. for the purpose of diagnosing cancer or a specified disease and that surgery results in a diagnosis of cancer or a specified disease; or
3. that is the first surgery performed subsequent to a diagnosis of cancer or a specified disease that is performed for the purpose of verifying the complete removal of the cancer or specified disease.

If any surgical procedure other than those listed in the Schedule of Surgical Procedures is performed, we pay the actual charges, up to the unit value for the surgical procedure as set forth in the 1964 California Relative Value Schedule (C.R.V.S.) multiplied by $10.00 per unit of coverage. If the surgical procedure has no unit value or is not shown in the 1964 C.R.V.S., we pay the actual charges, up to an amount we reasonably determine to be consistent (based upon relative difficulty) with the Schedule of Surgical Procedures per unit of coverage. Two or more procedures performed at the same time through one incision or entry point are considered one operation; we pay the amount for the procedure with the greatest benefit. Payment will never exceed the maximum per unit of coverage. Surgery performed on an outpatient basis is paid at 150% of the scheduled benefit. This benefit does not pay for surgeries covered by other benefits in this Schedule of Benefits.

L. Anesthesia. We pay 25% of the amount paid for the Surgery benefit (benefit K.) for anesthesia received by an anesthetist.

M. Bone Marrow or Stem Cell Transplant. We pay the amounts shown on page 3A for the following types of bone marrow or stem cell transplants performed on a covered person:
1. A transplant which is other than non-autologous.
2 A transplant which is non-autologous for the treatment of cancer or a specified disease, other than Leukemia.
3. A transplant which is non-autologous for the treatment of Leukemia.

This benefit is payable only once per covered person per calendar year.

A non-autologous transplant is an allogeneic or syngeneic graft from one human being to another.

N. Ambulatory Surgical Center. We pay the amount shown on page 3A for the use of an ambulatory surgical center for a surgical procedure covered under the Surgery Benefit (benefit K.) that is performed at an ambulatory surgical center.

O. **Second Opinion.** If surgery or treatment is recommended by a physician and the covered person chooses to obtain the opinion of a second physician, we pay the amount shown on page 3A. This second opinion must be: rendered prior to surgery or treatment being performed; and obtained from a physician not in practice with the physician rendering the original recommendation.

P. Inpatient Drugs and Medicine. We pay the amount shown on page 3A for charges per day, made by the hospital for drugs and medicine while hospital confined, for each day of continuous hospital confinement. This benefit does not pay for drugs and/or medicine covered under the Radiation/Chemotherapy benefit (benefit G.) or the Anti-Nausea benefit (benefit AA.).

Q. Physician's Attendance. We pay the amount shown on page 3A per day for a visit by a physician while a covered person is receiving treatment during hospital confinement. This benefit is limited to one visit by one physician per day of hospital confinement. A visit means personal attendance by the physician. Admission to the hospital as an inpatient is required.

R. Ambulance. We pay the amount shown on page 3A per continuous hospital confinement for transportation by a licensed ambulance service or a hospital owned ambulance to or from a hospital in which the covered person is confined.

S. Non-Local Transportation. We pay the following benefit for transportation to receive treatment at a hospital (inpatient or outpatient); or radiation therapy center; or chemotherapy or oncology clinic; or any other specialized freestanding treatment center nearest to the covered person's home, provided the same or similar treatment cannot be obtained locally: (1) actual cost of round trip coach fare on a common carrier; or (2) the amount shown on page 3A, up to 700 miles, for round trip personal vehicle transportation. Mileage is measured from the covered person's home to the nearest treatment facility as described above. "Non-Local" means a round trip of more than 70 miles from the covered person's home to the nearest treatment facility. We do not pay for: transportation for someone to accompany or visit the person receiving treatment; visits to a physician's office or clinic; or for services other than actual treatment.

T. Outpatient Lodging. We pay a daily lodging benefit when a covered person receives radiation or chemotherapy treatment (benefit G.) on an outpatient basis, provided the specific treatment is authorized by the attending physician and cannot be obtained locally. The benefit is for a single room in a motel, hotel, or other accommodations acceptable to us, for the amount shown on page 3A per day during treatment. This benefit is limited to the amount shown on page 3A per 12 month period beginning with the first day of benefit under this provision. Outpatient treatment must be received at a treatment facility more than 100 miles from the covered person's home.

U. Family Member Lodging and Transportation. We pay the following benefits for one adult member of the covered person's family to be near the covered person, when they are confined in a non-local hospital for specialized treatment:
1. ***Lodging*** **-** The actual cost of a single room in a motel, hotel, or other accommodations acceptable to us, up to the amount shown on page 3A per day. This benefit is limited to 60 days for each period of continuous hospital confinement; and
2. ***Transportation*** **-** The actual cost of round trip coach fare on a common carrier or a personal vehicle allowance of the amount shown on page 3A per mile, up to 700 miles per continuous hospital confinement. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. We do not pay the Family Member Transportation benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation benefit (benefit S.), when the family member lives in the same city or town as the covered person.

V. Physical or Speech Therapy. We pay the amount shown on page 3A per day, for physical or speech therapy for restoration of normal body function.

W. New or Experimental Treatment. We pay the actual charges, up to the limit stated below, for new or experimental treatment for cancer or a specified disease when:
1. the treatment is judged necessary by the attending physician; and
2. no other generally accepted treatment produces superior results in the opinion of the attending physician.

This benefit is limited to the amount shown on page 3A per 12 month period beginning with the first day of treatment under this provision. This benefit does not pay if benefits are payable for treatment covered under any other benefit in this Schedule of Benefits.

X. Prosthesis and Reconstructive Breast Surgery. We pay the following benefits for Prosthesis and Breast Reconstruction.

1. **Prosthesis.** We pay actual charges up to the amount shown on page 3A for prosthetic devices which are prescribed as a direct result of surgery for cancer or specified disease and which require surgical implantation. This benefit is limited to the amount shown on page 3A per covered person, per amputation.
2. **Reconstructive Breast Surgery.** We pay actual charges up to the amount shown on page 3A for reconstructive breast surgery following a mastectomy that is covered under this policy. This includes charges for the expense of reconstruction of the breast on which the mastectomy was performed; and surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses; and treatment of physical complications for all stages of the mastectomy, including lymphedemas; and at least 2 external postoperative prostheses. This benefit is limited to the amount shown on page 3A per covered person.

Y. Hair Prosthesis. We pay the amount shown on page 3A every 2 years, for a wig or hairpiece if the covered person experiences hair loss.

Z. Nonsurgical External Breast Prosthesis. We pay the actual costs up to the amount shown on page 3A for the initial, nonsurgical breast prosthesis following a covered mastectomy or partial mastectomy that is paid for under this policy. This benefit is not paid when the Prosthesis and Reconstructive Breast Surgery benefit (benefit X.) is paid.

AA. Anti-Nausea Benefit. We pay the actual costs up to the amount shown on page 3A per calendar year for anti-nausea medication prescribed for a covered person by a physician. We will not pay this benefit for medication administered while the covered person is an inpatient.

BB. Waiver of Premium. If, while this coverage is in force, the insured employee or member, as defined, becomes disabled due to cancer first diagnosed after the effective date of coverage and remains disabled for 90 days, we pay premiums due after such 90 days for as long as the insured employee or member remains disabled. The term "disabled" means that the insured employee or member is:
1. unable to work at any job for which they are qualified by education, training or experience; and
2. not working at any job for pay or benefits; and
3. under the care of a physician for the treatment of cancer.

This benefit is only available to the insured employee or member, as defined. It does not apply to any other covered person.

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OPTIONAL BENEFIT(S)

Cancer Initial Diagnosis. We pay a one-time benefit when a covered person is diagnosed for the first time in their life as having cancer other than skin cancer. The first diagnosis must occur after the effective date of coverage for that covered person. The benefit is the amount shown on page 3. The benefit is payable only once per covered person.

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OPTIONAL BENEFIT(S)

Wellness. We pay this benefit if a covered person has a wellness test performed. We pay the amount shown on page 3 per calendar year per covered person for any one of the wellness tests. Each covered person is covered for no more than the amount shown on page 3 per calendar year. We pay this benefit regardless of the result of the test. There is no limit as to the number of years we pay for wellness tests. The eligible wellness tests are:

1. Biopsy for skin cancer; and
2. Blood test for triglycerides; and
3. Bone Marrow Testing; and
4. CA15-3 (cancer antigen 15-3-blood test for breast cancer); and
5. CA125 (cancer antigen 125 – blood test for ovarian cancer); and
6. CEA (carcinoembryonic antigen – blood test for colon cancer); and
7. Chest X-ray; and
8. Colonoscopy; and
9. Doppler screening for carotids; and
10. Doppler screening for peripheral vascular disease; and
11. Echocardiogram; and
12. EKG (Electrocardiogram); and
13. Flexible sigmoidoscopy; and
14. Hemocult stool analysis; and
15. HPV (Human Papillomavirus) Vaccination; and
16. Lipid panel (total cholesterol count); and
17. Mammography, including Breast Ultrasound; and
18. Pap Smear, including ThinPrep Pap Test; and
19. PSA (prostate specific antigen – blood test for prostate cancer); and
20. Serum Protein Electrophoresis (test for myeloma); and
21. Stress test on bike or treadmill; and
22. Thermography; and
23. Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms.

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SCHEDULE OF SURGICAL PROCEDURES
PER UNIT OF SURGERY COVERAGE

SURGICAL PROCEDURE	PROCEDURE CODE FOR 1964 C.R.V.S.	PER UNIT OF SURGERY COVERAGE
BRAIN		
Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	61510	$1,250.00
Craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentorial	61512	$1,500.00
Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion	61575	$1,250.00
Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computerized axial tomography	61751	$1,400.00
BREAST		
Biopsy of breast; needle core (separate procedure)	19100	$ 25.00
Biopsy of breast; incisional	19101	$ 150.00
Excision of malignant tumor (except 19140), male or female, one or more lesions	19120	$ 150.00
Mastectomy, partial	19160	$ 150.00
Mastectomy, simple, complete	19180	$ 300.00
Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle	19240	$ 600.00
DIGESTIVE SYSTEM		
Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with collection of specimen(s) by brushing or washing (separate procedure)	43235	$ 150.00
Gastrectomy, total; with esophagoenterostomy	43620	$1,000.00
Colectomy, partial; with anastomosis	44140	$ 800.00
Proctectomy; complete, combined abdominoperineal, with colostomy, one or two stages	45110	$1,000.00
Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	45378	$ 280.00
Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	45385	$ 500.00
EXTERNAL GENITALIA		
FEMALE		
Vulvectomy, simple; partial	56620	$ 400.00
Vulvectomy, simple; complete	56625	$ 550.00
Vulvectomy, radical, partial	56630	$ 800.00
Vulvectomy, radical, complete, with inguinofemoral, iliac, and pelvic lymphadenectomy	56640	$1,000.00

SCHEDULE OF SURGICAL PROCEDURES (Continued)
PER UNIT OF SURGERY COVERAGE

SURGICAL PROCEDURE	PROCEDURE CODE FOR 1964 C.R.V.S.	PER UNIT OF SURGERY COVERAGE
EXTERNAL GENITALIA (CONT)		
MALE		
Biopsy of testis, needle (separate procedure)	54500	$ 20.00
Orchiectomy, radical, for tumor; inguinal approach	54530	$ 400.00
LIVER		
Biopsy of liver; percutaneous needle	47000	$ 50.00
Biopsy of liver, wedge (separate procedure)	47100	$ 400.00
Hepatectomy, resection of liver; partial lobectomy	47120	$ 800.00
LUNG		
Bronchoscopy; with biopsy	31625	$ 200.00
Biopsy, lung or mediastinum, percutaneous needle	32405	$ 50.00
Removal of lung, total pneumonectomy	32440	$1,000.00
MUSCULOSKELETAL		
Biopsy, bone, trocar or needle; superficial (e.g., ilium, sternum, spinous process, ribs)	20220	$ 50.00
Excision of tumor, soft tissue of neck or thorax; deep, subfascial, intramuscular	21556	$ 100.00
Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical	63275	$1,000.00
PROSTATE		
Transurethral resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	52601	$ 800.00
Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)	55801	$ 800.00
Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	55845	$1,300.00
SKIN		
Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); single lesion (pathology report required)	11100	$ 30.00
Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); each separate/additional lesion (pathology report required)	11101	$ 15.00

SCHEDULE OF SURGICAL PROCEDURES (Continued)
PER UNIT OF SURGERY COVERAGE

SURGICAL PROCEDURE	PROCEDURE CODE FOR 1964 C.R.V.S.	PER UNIT OF SURGERY COVERAGE
SKIN (CONT)		
Excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.5 cm. or less	11600	$ 60.00
Excision, malignant lesion, trunk, arms, or legs; lesion diameter 2.1 to 3.0 cm	11603	$ 120.00
Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm. or less	11620	$ 100.00
Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 2.1 to 3.0 cm.	11623	$ 250.00
Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 cm. or less	11640	$ 150.00
Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 2.1 to 3.0 cm. .	11643	$ 300.00
Chemosurgery (Mohs' micrographic technique); first state, fresh tissue technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, and microscopic examination of specimens by the surgeon, of up to 5 specimens	17304	$ 200.00
UTERUS		
Colposcopy (vaginoscopy); with biopsy(s) of the cervix and/or endocervical curettage	57454	$ 60.00
Endometrial and/or endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)	58100	$ 30.00
Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	58120	$ 150.00
Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)	58150	$ 600.00
Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube, with or without removal of ovary(s)	58210	$1,000.00
Vaginal hysterectomy	58260	$ 600.00
VASCULAR INJECTION PROCEDURES		
Placement of central venous catheter for therapeutic reasons (subclavian, jugular, or other vein) (e.g., for hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2	36489	$ 100.00
Insertion of implantable venous access port, with or without subcutaneous reservoir	36533	$ 400.00
Removal of implantable venous access port and/or subcutaneous reservoir	36535	$ 150.00

CLAIM INFORMATION

NOTICE OF CLAIM

We encourage the insured employee or member to notify us of claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by this policy, or as soon as is reasonably possible. Notice given by, or on behalf of, the insured employee, the member or the beneficiary to us at 1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687, or to any authorized agent of ours, with the insured employee's or member's name and certificate number, is notice to us.

The claim form can be requested from us. If it is not received within 15 days of the request, written proof of the claim may be sent to us without waiting for the form.

FILING A CLAIM

The insured employee or member and the employer must complete their own sections of the claim form and then give it to the attending physician. The physician should complete his or her section of the form and send it directly to us.

PROOF OF CLAIM

If this policy provides for periodic payment of a continuing loss, written proof of loss must be given to us within 90 days after the end of each period for which we are liable. For any other loss, written proof must be given to us within 90 days after each loss. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 1 year from the time specified unless the insured employee or member is legally incapacitated.

COOPERATION OF BENEFICIARY

The beneficiary must reasonably cooperate during any investigation and/or adjudication of a claim. This includes the authorization for the release of medical records and other information.

PHYSICAL EXAMINATION AND AUTOPSY

We have the right, at our own expense, to have any covered person examined by a physician of our choosing, as often as may be reasonably required while a claim is pending. We may have an autopsy performed during the period of contestability, where it is not forbidden by law.

PAYMENT OF CLAIMS

After receiving written proof of claim, we will immediately pay all benefits then due under this policy. Benefits for any other loss covered by this policy are paid upon our receipt of proper written proof.

We will make payments to the insured employee or member unless he or she assigns such payments. Any amounts unpaid at the insured employee's or member's death may, at our option, be paid either to the named beneficiary or to the insured employee's or member's estate.

If benefits are payable to the insured employee's or member's estate or a beneficiary who cannot execute a valid release, we can pay benefits up to $1,000, to someone related to the insured employee or member or beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

ASSIGNMENT

An assignment of the coverage under this policy is not binding on us, unless:
1. it is a written request; and
2. it is received and recorded by us at our home office.

We are not responsible for the validity of any assignment. An assignment is subject to any payment we make or other action we take before we record the assignment. An assignment may not change the owner or beneficiary.

CLAIM INFORMATION (Continued)

OVERPAID CLAIM

We have the right to correct benefit payments that are made in error. The insured employee or member has the responsibility to return any overpayment to us. We have the responsibility to make additional payments if any underpayments have been made.

CLAIM REVIEW

If a claim is denied, we will give written notice of:

1. the reason for denial; and
2. the policy provision that relates to the denial; and
3. the insured employee's or member's right to ask for a review of his or her claim; and
4. the right to submit any additional information that might allow us to change our decision.

The insured employee or member may, upon written request, read any reports that are not confidential. For a fee, we will make copies of those reports.

APPEALS PROCEDURE

Prior to filing any lawsuit and within 60 days after denial of a claim, the insured employee or member or his or her beneficiary must appeal any denial of benefits under the policy by making a written request for review of the denial.

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GLOSSARY

Active Employment. Means the employee or member is working for the employer for earnings that are paid regularly and that he or she is performing the material and substantial duties of his or her regular occupation. The employee or member must be working at least the minimum number of hours as described under Eligible Class(es) in each plan. The employee or member will be deemed to be in active employment on a day which is not the employer's scheduled work days only if he or she was actively employed on the preceding scheduled work day.

The employee's or member's work site must be:
1. the employer's usual place of business; or
2. an alternative work site at the direction of the employer; or
3. a location to which the job requires such employee or member to travel.

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. Temporary and seasonal workers are excluded from coverage.

Actual Charge. Means the amount billed for a treatment or service before any insurance discounts, other insurance payment, reductions or discounts of any kind.

Actual Cost. Means the amount actually paid by or on behalf of the covered person and accepted by the provider as full payment for the particular goods or services provided.

Ambulatory Surgical Center. Means a licensed surgical center consisting of: an operating room; facilities for the administration of general anesthesia; and a post surgery recovery room that the patient is admitted to and discharged from within the same working day. This includes an ambulatory surgical center that is a part of a hospital.

Autologous Bone Marrow Transplant. Means a procedure in which bone marrow is removed from a patient, stored, and then given back to the patient following intensive treatment.

Bone Marrow Transplant. Means a procedure to replace bone marrow destroyed by treatment with high doses of anticancer drugs or radiation. A transplant may be autologous (the person's own marrow saved before treatment), allogeneic (marrow donated by someone else), or syngeneic (marrow donated by an identical twin).

Calendar Year. Means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

Cancer. Means a disease manifested by the presence of a malignancy characterized by the uncontrolled and abnormal growth and spread of malignant cells in any part of the body. This includes: Hodgkin's Disease; leukemia; lymphoma; carcinoma; sarcoma; or malignant tumor. It does not include other conditions which may be considered precancerous, such as: leukoplakia; actinic keratosis; carcinoid; hyperplasia; polycythemia; nonmalignant melanoma; moles; or similar diseases or lesions.

Common Carrier. Means only the following: commercial airlines; or passenger trains; or inter-city buslines. It does not include taxis; intra-city buslines; or private charter planes.

Continuous Hospital Confinement. Means one continuous confinement or two or more hospital confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

Covered Person. Means any of the following:
1. any eligible family member (including the employee or member) named on the enrollment form or evidence of insurability form and acceptable for coverage by us; or
2. any eligible family member added by endorsement after the effective date; or
3. a newborn child.

Date of Diagnosis. Means the earliest of the date of: tentative diagnosis; or clinical diagnosis; or the day the tissue specimen, culture(s) and/or titer(s) are taken, upon which the positive or tentative diagnosis of cancer or specified disease is made.

GLOSSARY (Continued)

Domestic Partner. Means the employee's or member's same-sex or opposite-sex partner who is eligible for coverage providing that:

1. both the employee or member and the employee's or member's same-sex or opposite sex partner must be considered as domestic partners according to the law of employee's or member's state of residence; or
2. if the employee's or member's state of residence has no domestic partnership laws, but the policyholder seeks to provide insurance benefits to domestic partners, the employee or member must satisfy the definition of domestic partner as defined by the policyholder; or
3. if the employee's or member's state of residence has no domestic partnership law and the policyholder has no domestic partnership definition, but the policyholder seeks to provide insurance benefits to domestic partners, then both the employee and member and the employee's or member's same-sex or opposite sex partner must:
   a. have resided together in the same permanent residence; and
   b. be at least 18 years of age; and
   c. intend to remain each other's sole domestic partner indefinitely; and
   d. be emotionally committed to one another and share joint responsibilities for the common welfare and financial obligations of one another; or the domestic partner must be chiefly dependent upon the employee or member for care and financial assistance; and
   e. not be legally married to or the legal domestic partner of anyone else; and
   f. not be related by blood closer than would prohibit marriage under applicable state law.

If requested by us, satisfactory proof must be submitted that supports the domestic partner's eligibility for coverage.

Employee. Means a person who is: (a) a citizen or resident of the United States or one of its territories; and (b) in active employment with the employer or is a member in good standing in the labor union, association or other entity named as the policyholder.

Employer. Means the individual, company or corporation where the employee or member is in active employment, and includes any division, subsidiary, or affiliated company named in this policy.

Evidence of Insurability. Means a statement of the employee's or member's or a dependent's medical history which we will use to determine if he or she is approved for coverage. Evidence of insurability will be provided at such person's expense.

Extended Care Facility. Means a licensed nursing facility under the direction of a physician which provides continuous skilled nursing service under the supervision of a graduate registered nurse (R.N.) and maintains daily medical records on each patient. It does not include any institution, or part thereof, used primarily as a place for the aged, drug addicts, alcoholics, or rest.

Family Coverage. Means coverage that includes the insured employee or member as defined, his or her spouse or domestic partner and eligible children.

Freestanding Hospice Care Center. Means a center which is not a hospital, a wing, or section of a hospital, providing 24 hours a day care for the terminally ill under the medical direction of a physician.

Grace Period. Means a period of31days following the premium due date during which premium payment may be made.

Hospital. Means a legally operated institution with established facilities (either on its premises or available to the hospital on a contractual, pre-arranged basis and under the supervision of a staff of one or more duly licensed physicians), for the care and treatment of sick and injured persons for diagnosis, surgery, and 24 hour nursing service. Hospital does not include:

1. any institution which is mainly a rest home, nursing home, convalescent home, or home for the aged; or
2. any institution which is mainly for the care and treatment of alcoholics or drug addicts, or mental or nervous disorders.

GLOSSARY (Continued)

Individual and Child(ren) Coverage. Means coverage that includes only the insured employee or member, as defined and eligible children.

Individual and Spouse Coverage. Means coverage that includes only the insured employee or member, as defined, and his or her eligible spouseor domestic partne.

Individual Coverage. Means coverage that includes only the insured employee or member, as defined.

Initial Enrollment Period. Means one of the following periods during which the employee or member may first apply in writing for coverage under this policy:

1. if the employee or member is eligible for coverage on the policy effective date, a period before the policy effective date as set by us and the policyholder; or
2. if the employee or member becomes eligible for coverage after the policy effective date, the period ending 31 days after the date he or she is first eligible to apply for coverage.

Insured Employee or Member. Means the employee or member accepted for coverage by us who has completed and signed the enrollment form or evidence of insurabilityand whose name appears on the certificate specification page.

Intoxication. Means a temporary state of being as determined by the laws of the state in which the loss occurred.

Material and Substantial Duties. Means duties that:

1. are normally required for the performance of the employee's or member's regular occupation; and
2. cannot be reasonably omitted or modified, except that if the employee or member is required to work on average in excess of 40 hours per week, we will consider such person able to perform that requirement if he or she is working or has the capacity to work 40 hours per week.

Member. Means a member in good standing in an labor union, association or other entity named as the policyholder and who is: (a) a citizen or resident of the United States; and (b) is(1) engaged in , or (2) able to engage in and currently seeking, active employment.

Non-Autologous Bone Marrow Transplant. Means an allogeneic or syngeneic graft of living bone marrow from one human being to another.

Nurse. Means any one of the following who is not a member of the covered person's immediate family or employed by the hospital where the covered person is confined:

1. a licensed practical nurse (L.P.N.); or
2. a licensed vocational nurse (L.V.N.); or
3. a graduate registered nurse (R.N.).

Oncologist. Means a legally licensed Doctor of Medicine or Doctor of Osteopathic Medicine certified to practice in the field of Oncology.

Pathologist. Means a legally licensed Doctor of Medicine or Doctor of Osteopathic Medicine certified by the American Board of Pathology to practice Pathological Anatomy.

Payable Claim. Means a claim for which we are liable under the terms of this policy.

Physician. Means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

We will not recognize the insured employee or member, his or her spouse, children, parents, or siblings as a physician for a claim.

GLOSSARY (Continued)

Policyholder. Means the legal entity to whom this policy is issued.

Positive Diagnosis (of cancer). Means a diagnosis by a licensed Doctor of Medicine certified by the American Board of Pathology to practice Pathological Anatomy, or an Osteopathic Pathologist. Diagnosis is based on a microscopic examination of fixed tissue, or preparations from the hemic system (except for skin cancer). We accept clinical diagnosis of cancer as evidence that cancer existed in a covered person when a pathological diagnosis cannot be made, provided medical evidence substantially documents the diagnosis and the covered person received definitive treatment for the cancer.

Positive Diagnosis (of a specified disease). Means a diagnosis by a qualified physician based on generally accepted diagnostic procedures and criteria.

Pre-Existing Condition. Means a disease or physical condition for which:

1. symptoms existed within the 12 month period prior to the effective date of coverage; or
2. medical advice or treatment was recommended or received from a member of the medical profession within the 12 month period prior to the effective date of coverage.

A pre-existing condition can exist even though a diagnosis has not yet been made.

Radiologist. Means a person who is licensed to administer X-ray therapy, radium therapy, or radio-active isotopes therapy and is certified by the American Board of Radiology.

Re-Enrollment Period. Means a period of time as set by the policyholder and us during which the employee or member may apply, in writing, for coverage under this policy, or change coverage under this policy if he or she is currently enrolled.

Specified Disease. Only any one of the following:

1. Addison's Disease
2. Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
3. Brucellosis
4. Cerebrospinal Meningitis (bacterial)
5. Cystic Fibrosis
6. Diphtheria
7. Encephalitis
8. Hansen's Disease
9. Hepatitis (Chronic B or Chronic C with liver failure or hepatoma)
10. Legionnaire's Disease (confirmation by culture or sputum)
11. Lyme Disease
12. Multiple Sclerosis
13. Muscular Dystrophy
14. Myasthenia Gravis
15. Osteomyelitis
16. Poliomyelitis
17. Primary Biliary Cirrhosis
18. Primary Sclerosing Cholangitis (Walter Payton's Liver Disease)
19. Rabies
20. Reye's Syndrome
21. Rocky Mountain Spotted Fever
22. Scarlet Fever
23. Sickle Cell Anemia
24. Systemic Lupus Erythematosus
25. Tetanus
26. Thallasemia
27. Tuberculosis
28. Tularemia
29. Typhoid Fever

Stem Cell Transplant. Means a method of replacing immature blood and bone marrow cells that were destroyed by cancer treatment. The stem cells are given to the person after treatment to help the bone marrow recover and continue producing healthy blood cells.

Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence. Means the employee or member is absent from active employment for a period of time that has been agreed to in advance in writing by the current employer.

Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

Tentative Diagnosis. Means a diagnosis based upon dated medical records which indicate a diagnosis of a probable or possible cancer or specified disease.

We, Us, and **Our.** Means American Heritage Life Insurance Company.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

Endorsement

This Endorsement is made a part of the Group Policy to which it is attached. It is subject to all of the provisions, limitations and exclusions of the Group Policy not inconsistent with this Endorsement.

The CERTIFICATES OF INSURANCE provision in the GENERAL PROVISIONS section is deleted in its entirety and replaced with the following:

CERTIFICATES OF INSURANCE

We will furnish to the policyholder a certificate of insurance for delivery to each insured employee or member. The certificate will provide a description of the insurance provided by this policy and will state:

1. the essential features of the insurance coverage; and
2. to whom benefits are payable.

If there is any discrepancy between the provisions of any certificate and the provisions of this policy, the provisions of this policy govern.

All other requirements of the policy not specifically stated within this endorsement still apply.

Secretary

GPOLCD

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

Endorsement

This Endorsement is made part of the Policy to which it is attached. It is subject to all of the provisions, limitations and exclusions of the Policy, not inconsistent with this Endorsement.

All references to the eligibility and termination of dependents are revised to the following:

Eligible dependents are the insured employee's or member's:
1. legal spouse or domestic partner; and
2. children and domestic partner's children.

A child is a person under age 26 who is:
1. the insured employee's or member's or his or her domestic partner's natural or adopted son or daughter, stepson or stepdaughter; or
2. a foster child who is placed with the insured employee or member or his or her domestic partner by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

If the insured employee's or member's spouse is a covered person, his or her spouse's coverage ends upon valid decree of divorce or the insured employee's or member's death.

If the insured employee's or member's domestic partner is a covered person, his or her domestic partner's coverage ends upon termination of the domestic partnership or the insured employee's or member's death.

Coverage for a child will end on the issue day of the month that follows when the child: (a) reaches age 26; or (b) otherwise does not meet the requirements of an eligible dependent.

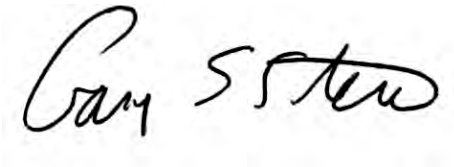
Coverage does not end for an incapacitated dependent child who:
1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and
3. is chiefly dependent upon the insured employee or member for support and maintenance.

Coverage for an incapacitated dependent child continues as long as the policy remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished, in writing, to us when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as often as may be required, but no more often than annually after the 2 year period following the child's attainment of the limiting age for eligibility.

Domestic Partner means the insured employee's or member's same-sex or opposite-sex partner who is eligible for coverage provided that:
1. both the insured employee or member and his or her same-sex or opposite-sex partner must be considered as domestic partners according to the law of their state of residence; or
2. if their state of residence has no domestic partnership laws, they must satisfy the definition of domestic partner as defined by the policyholder.

Issue day means the same day of the month as the policy date.

All other requirements of the policy not specifically stated within this endorsement still apply.



Secretary

AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

THIS IS LIMITED BENEFIT CANCER AND SPECIFIED DISEASE COVERAGE WHICH ONLY PROVIDES BENEFITS FOR CANCER AND SPECIFIED DISEASES AS DEFINED AND OTHER OPTIONAL BENEFITS DESCRIBED HEREIN

Important Privacy Policy Notice

At Allstate Benefits ("AB"), we value you as a customer. We also share your concerns about privacy. We are sending this notice to explain how we treat personal information ("customer information") that is not public. This is information that we obtain from you or other sources when we provide you with products and services.

We want you to know that: we respect your privacy; and we protect your information.

- We do not sell customer information.
- We do not share your information with: persons; companies; or organizations outside of AB that would use that information to contact you about their products and services.
- We expect persons or organizations that provide services on our behalf to keep your information confidential. We also expect them to use your information only to provide the services we've asked them to perform.
- We communicate to our employees about the need to protect your information. We have established safeguards (these are physical, electronic and procedural) to protect this information.

Below are answers to questions that you might have about privacy. You may be wondering...

What do we do with your information?

AB does not sell your customer or medical information to anyone. We do not share it with companies or organizations outside of AB that would use that information to contact you about their own products and services. If this were to change, we would offer you the option to opt out of this type of information sharing. Also, we would obtain your consent before we share medical information for marketing purposes.

Your agent or broker may use your information to help you with your insurance needs. We may also communicate with you about products, features, and options in which you have expressed an interest. Without your consent, we may provide your information to persons or organizations in and out of AB. This would be done as permitted or required by law. We may do this to:

- Fulfill a transaction you have requested.
- Service your policy.
- Market our products to you.
- Investigate or handle claims.
- Detect or prevent fraud.
- Participate in insurance support organizations (Information from a report by an insurance support organization may be retained by that organization and distributed to other persons.).
- Comply with lawful requests from regulatory and law enforcement authorities.

These persons or organizations may include:

- Our affiliated companies.
- Companies that perform services, including marketing, on our behalf.
- Other financial institutions with which we have an agreement for the sale of financial products.
- Other insurance companies to perform their role in an insurance transaction involving you.
- Businesses that conduct actuarial or research studies.
- Persons requesting information pursuant to a subpoena or court order.
- Your agent or broker.
- An employer, if your premiums are payroll deducted.
- The creditor who sold you insurance, if your policy is credit insurance.

What kind of customer information do we have, and where did we get it?
Much of the information that we have about you comes from you. When you perform certain transactions, you may give us information such as your name, address, and Social Security number. These transactions include when you submit: an application for insurance; a request for insurance; a request for products and services we offer; or a request for an insurance quote. We may have contacted you by telephone or mail for additional information. We keep information about the types of services you purchase from us and our affiliates. Examples of this include premiums, fund values, and payment history. We may collect information from outside sources such as consumer reporting agencies and health care providers. The information we collect may include the following:

- Motor vehicle reports.
- Credit reports.
- Medical information.

How do we protect your customer information?
We expect any company with whom we share your information to use it only to provide the service we have asked them to perform. Information about you is also available within AB to those individuals who may need to use it to fulfill and service the needs of our customers. We communicate the need to protect your information to all employees and agents. We especially communicate this need to individuals who have access to it. Plus, we have established physical, electronic, and procedural safeguards to protect your information. Note that if your relationship with us ends, your information will remain protected. This protection will be provided according to our privacy practices outlined in this Important Notice.

How can you find out what information we have about you?
You may request to see, or obtain by mail, the information about you in our records. If you believe that our information is incomplete or inaccurate, you may request that we correct, add to, or delete from the disputed information. In order to fulfill your request, we may make arrangements to copy and disclose your information to you on our behalf. This may be done with an insurance support organization or a consumer reporting agency. You may also request a more complete description of the entities to which we disclose your information, or the conditions that might warrant such disclosures. Please send any of the requests listed above in writing to:

AB
Policyholder Services (Privacy Section)
1776 American Heritage Life Drive
Jacksonville, FL 32224-6687

If you are an Internet user …
Our website, www.allstateatwork.com, provides information about AB, our products, and the agencies and brokers that represent us. You may also perform certain transactions on the website. When accessing www.allstateatwork.com, please be sure to read the Privacy Statement that appears there. To learn more, the www.allstateatwork.com Privacy Statement provides information relating to your use of the website. This includes, for example:

1) our use of online collecting devices known as “cookies”;
2) how we collect information such as IP address (the number assigned to your computer when you use the Internet), browser and platform types, domain names, access times, referral data, and your activity while using our site;
3) who should use our website;
4) the security of information over the Internet;
5) links and co-branded sites.

We hope you have found this notice helpful. If you have any questions or would like more information, please don’t hesitate to contact your agent or write us at:

AB
Policyholder Services (Privacy Section)
1776 American Heritage Life Drive
Jacksonville, FL 32224-6687

This notice is being provided on behalf of the following companies:

American Heritage Life Insurance Company
Bluegrass Life Insurance Company
Acme United Insurance Company
SMA Life Assurance Company
Holiday Life Insurance Company
Kentucky Home Mutual
Keystone State Life
National Guardian Life

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE APRIL 14, 2003

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of our Plan's customers' Protected Health Information, to provide those customers with notice of our legal duties and privacy practices with respect to Protected Health Information, and to send notification to affected customers if there is a breach of unsecured Protected Health Information. If your state provides privacy protections that are more stringent than those provided by HIPAA, we will maintain your Protected Health Information in accordance with the more stringent state standard.

This Notice applies to "Protected Health Information" associated with "Health Plans" issued by American Heritage Life Insurance Company.

This Notice describes how we may use and disclose Protected Health Information to perform claims handling, payment, general insurance operations, and for other purposes that are permitted or required by law. Use or disclosure of your Protected Health Information for the purposes described in this Notice may be made in writing, orally, or by electronic means.

We are required to abide by the terms of this Notice. However, we may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all of your Protected Health Information that we maintain, including any information we created or received prior to issuing the new notice. If we make a material revision to our Privacy Notice, copies will be sent to you if you are then currently insured under our Plan.

Protected Health Information means information about you that is created or received by us and during the administration of coverage under the Plan, which identifies you or for which there is a reasonable basis to believe the information can be used to identify you and that relates to:

1) the past, present or future physical or mental health condition of the individual; or
2) the provision of health care to the individual; or
3) the past, present or future payment for the provision of health care to the individual.

Uses and Disclosures of Protected Health Information With Your Written Authorization

Except as described in the next section of this Notice, we will not use or disclose your Protected Health Information for any purpose unless you have signed a form authorizing the use or disclosure. For example, most uses and disclosures of psychotherapy notes, uses and disclosures of Protected Health Information for marketing purposes, and disclosures that constitute a sale of Protected Health Information will be made only with your authorization. You have the right to revoke that authorization in writing at any

time, except to the extent that we have already taken action in reliance on the authorization; or the authorization was obtained as a condition of obtaining coverage, to the extent that other law allows the insurer to contest a claim under the policy or the policy itself.

Uses and Disclosures of Protected Health Information Without Your Written Authorization

For Payment. We may make use of and disclose your Protected Health Information without your written authorization as may be necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims or certify these services are covered under your Plan.

For Plan Administrative Operations. We may make use of and disclose your Protected Health Information without your written authorization as necessary for our Plan administrative operations. Plan administrative operations include our usual business activities, examples of which are management, licensing, peer review, quality improvement and assurance, enrollment, underwriting, reinsurance, compliance, auditing, rating, claims handling, complaint handling and other functions related to your Plan. We are prohibited from using or disclosing genetic information for underwriting purposes.

To Individuals Involved In Your Care. We may, without your written authorization, for the purposes of treatment, payment or Plan administrative operations, disclose the fact that you are covered under a Plan or that payment has been processed to a family member, other relative, your close personal friend or any other person you may identify. In these circumstances, we would not disclose any Protected Health Information which is not directly relevant to that person's involvement with your care or with payment for your care.

If you have designated a person to receive information regarding payment of the premium or pay premium via credit card, we may inform that person or credit card facility when your premium has not been paid or received by us.

We may also disclose limited Protected Health Information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

To Our Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations. Examples of these may include, but are not limited to our duly appointed insurance agents, financial auditors, reinsurers, legal services, enrollment and billing services, claim payment and medical management services. We may provide access to your Protected Health Information without your written authorization to one or more of these outside persons or organizations who assist us with payment or Plan administrative operations. We require these business associates to appropriately safeguard the privacy of your information.

To Plan Sponsors. If you are enrolled in a group health plan, we may share summary health information with your employer, union, or other employee organization that sponsors and maintains the group health plan, for purposes of obtaining premium bids; or modifying, amending, or terminating the group health plan; or enrollment and disenrollment information. Summary health information excludes genetic information.

For Other Products and Services. We may contact you without your written authorization to provide information regarding Plan upgrades or additional benefits that may be of interest to you. For example, we may use the fact that you currently are insured under a Plan for the purpose of communicating to you about changes to our Plan or products that could enhance or add value to existing coverage.

For Disclosure With Authorization. Unless otherwise excluded in this notice, we will not disclose any other Protected Health Information to any person or entity not specifically mentioned elsewhere in this Notice without your express written authorization.

For Other Uses and Disclosures. We are permitted or required by law to make some other uses and disclosures of your Protected Health Information without your authorization. We may release your Protected Health Information:

- if required by law to a government authorized health oversight agency or company conducting audits, investigations, or civil or criminal proceedings.

- if required to do so by a court or administrative ordered subpoena or discovery request. In most cases you will have notice of such a release.

- for public health activities, such as required reporting of disease, injury, birth and death and for required public health investigations.

- as required by law if we suspect child abuse or neglect or if we believe you to be a victim of abuse, neglect or domestic violence.

- to the Food and Drug Administration if necessary to report adverse events, product defects or to participate in product recalls.

- to law enforcement officials as required by law to report wounds, injuries or crimes.

- to coroners, medical examiners and/or funeral directors consistent with law.

- for a national security or intelligence activity or, if you are a member of the military, as required by the armed forces.

- to workers' compensation agencies or similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Your Rights

Right to Inspect and Copy Your Protected Health Information. You may have access to our records that contain your Protected Health Information in order to inspect and obtain copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from our Privacy Officer and submit the completed form to our Privacy Office. If you request copies, we may charge you copying and mailing costs. If you request a copy of your Protected Health Information in electronic form, we will provide it to you electronically only if the record is readily producible in electronic form.

Right to Amend Your Protected Health Information. You have the right to request that we amend your Protected Health Information maintained in our enrollment, payment, claims adjudication and case or medical management records, or other records we use to make decisions about you. If you desire to amend these records, please obtain an amendment request form from our Privacy Officer and submit the completed form to our Privacy Office. We will comply with your request unless special circumstances apply. If your physician or other health care provider created the information that you desire to amend, you should contact the provider to amend the information.

Right to an Accounting of the Disclosures of Your Protected Health Information. Upon request, you may obtain an accounting of certain disclosures of your Protected Health Information made by us on or after April 14, 2003, excluding disclosures made earlier than six years before the date of your request. If you request an accounting more than once during any 12 month period, we will charge you a reasonable fee for the subsequent accounting statements.

Right to Request Confidential Communications. We will accommodate your reasonable request to receive communications of your Protected Health Information from us by alternative means of communication or at alternative locations if the request clearly states that disclosure of that information could endanger you.

Right to Request Restrictions on Use and Disclosure of Your Protected Health Information. You have the right to request restrictions on some of our uses and disclosures of your Protected Health Information to family members and others involved in your care or payment for care; or some of our uses and disclosures used to carry out treatment, payment, or Plan administrative operations, by notifying us of your request for a restriction in writing mailed to the contact identified at the end of this Notice. Your request must describe in detail the restriction you are requesting. We are not required to agree to your restriction request but will attempt to accommodate your requests. We retain the right to terminate an agreed-to restriction. In the event of a termination of an agreed-to restriction by us, we will notify you of such termination, but the termination will only be effective for Protected Health Information we receive after we have notified you of the termination. You also have the right to terminate any agreed-to restriction by contacting us using the "Contact Information" provided at the end of this Notice.

Personal Representatives. You may exercise your rights through a personal representative who will be required to produce evidence of his or her authority to act on your behalf. Proof of authority may be made by a notarized power of attorney, a court order of appointment of the person as your legal guardian or conservator, or if you are the parent of a minor child. We reserve the right to deny access to your personal representative.

Right to Receive Paper Copy of this Notice. You may obtain a copy of this Notice. You may obtain a paper copy of this Notice even if you agreed to receive such notice electronically. Please contact us and we will mail it to you.

Complaints

If you believe your privacy rights have been violated, you can file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Plan, send it in writing to the "Contact Information" at the address listed at the end of this Notice. There will be no retaliation for filing a complaint.

You may obtain a copy of this Notice by writing to us at the contact address below.

Contact Information

If you have questions or need further assistance regarding this Notice, you may contact:

Allstate Benefits
Attn: HIPAA Privacy Officer
1776 American Heritage Life Drive
Jacksonville, Florida 32224

Or, you may telephone the Customer Care Center at 1-800-521-3535.

GENERAL PURPOSES AND LIMITATIONS OF THE
KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
K.S.A. 40-3001 et. seq.

DISCLAIMER

THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MAY NOT PROVIDE COVERAGE FOR ALL OR A PORTION OF THIS POLICY. IF COVERAGE IS PROVIDED, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS AND EXCLUSIONS, AND IS CONDITIONED UPON RESIDENCY IN THIS STATE. THEREFORE, YOU SHOULD NOT RELY UPON COVERAGE BY THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELECTING AN INSURANCE COMPANY OR IN SELECTING AN INSURANCE POLICY. INSURANCE COMPANIES AND THEIR AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELLING YOU ANY FORM OF AN INSURANCE POLICY, OR TO INDUCE YOU TO PURCHASE ANY FORM OF AN INSURANCE POLICY. EITHER THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE KANSAS INSURANCE DEPARTMENT WILL RESPOND TO ANY QUESTIONS YOU MAY HAVE REGARDING THIS DOCUMENT.

Kansas Life and Health Insurance Guaranty Association
2909 SW Maupin Lane
Topeka, KS 66614

Kansas Insurance Department
420 SW 9th Street
Topeka, KS 66612

This is a brief summary of the Kansas Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. If there is any inconsistency between this notice and Kansas law, then Kansas law will control.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Kansas law, with funding from assessments paid by other insurance companies. This safety net was created under Kansas law, which determines who and what is covered and the amounts of coverage. The basic protections provided by the Association are:

- Life Insurance
  $300,000 in death benefits
  $100,000 in cash surrender or withdrawal values
- Health Insurance
  $500,000 in hospital, medical and surgical insurance benefits
  $300,000 in disability insurance benefits
  $300,000 in long-term care insurance benefits
  $100,000 in other types of health insurance benefits
- Annuities
  $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits, as well as certain aggregate limits.

USD #262 VALLEY CENTER

WELFARE BENEFIT PLAN

Summary Plan Description

USD #262 VALLEY CENTER WELFARE BENEFIT PLAN
SUMMARY PLAN DESCRIPTION
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SUMMARY PLAN DESCRIPTION
USD #262 VALLEY CENTER WELFARE BENEFIT PLAN

USD #262 Valley Center ("Employer") maintains the USD #262 Valley Center Welfare Benefit Plan ("Plan") for the exclusive benefit of, and to provide benefits to, its Eligible Employees, their legal Spouses, and their eligible dependents.

This Summary Plan Description ("SPD") describes the basic features of the Plan, how the Plan operates, and the benefits that can be purchased through the Plan. This SPD is only a summary of the key parts of the Plan, and a brief description of your rights as a Participant. It is not a part of the official plan documents. ***If there is a conflict between the plan documents and this SPD, the plan documents will control.***

(1) General Information

(a) *Type of Plan.* The Plan is a cafeteria plan.

(b) *Pre-Tax Benefits.* Participants in the Plan may reduce their salary on a pre-tax basis to pay for the cost of benefits provided by one or more of the following plans maintained by the Employer:

(i) USD #262 Valley Center Medical Plan ("Medical Plan");

(ii) USD #262 Valley Center Dental Plan ("Dental Plan");

(iii) USD #262 Valley Center Health Flexible Spending Account ("Health FSA");

(iv) USD #262 Valley Center Dependent Care Assistance Plan ("DCAP"); and/or

(v) USD #262 Valley Center Vision Plan ("Vision Plan").

Each of the above Pre-Tax Benefits is governed by a plan document. Please refer to such document for information regarding specific terms and conditions associated with each plan. This SPD serves as the summary plan description for each of these Pre-Tax Benefits. A summary of each of these plans is provided later in this SPD.

(c) *Taxation of Pre-Tax Benefits.* The amount by which your salary is reduced to purchase benefits, and any benefits paid to you under these pre-tax plans, will not be included in your taxable income for federal income tax purposes and is not subject to FICA taxes.

(d) *After-Tax Benefits.* Participants in the Plan may reduce their salary on an after-tax basis to pay for the cost of benefits provided by one or more of the following plans maintained by the Employer:

(i) USD #262 Valley Center Voluntary Life Plan ("Voluntary Life Plan");

(ii) USD #262 Valley Center Short Term Disability Plan ("Short Term Disability Plan"); and/or

(iii) USD #262 Valley Center Allstate After-Tax Plan ("Allstate After-Tax Plan").

This SPD serves as the summary plan description for each of these plans. A summary of each of these plans is provided later in this SPD.

(e) *Employer-Paid Benefit.* The USD #262 Valley Center Group Life Plan ("Group Life Plan") is an Employer-Paid Benefit available through this Plan.

This SPD serves as the summary plan description for this plan. A summary of this plan is provided later in this SPD.

(f) *Employer.* The name, address, telephone number, and federal tax identification number of the Employer are:

USD #262 VALLEY CENTER
143 S. MERIDIAN AVE.
VALLEY CENTER, KS 67147
(316) 755-7000
EIN: 48-0600478

(g) *Plan Administrator/Service of Process.* The Employer is the Plan Administrator. The Plan Administrator is responsible for providing you and other Participants with information regarding your rights and benefits under the Plan. The Plan Administrator must also file various reports, forms, and returns with the Department of Labor ("DOL") and the Internal Revenue Service ("IRS"). The Plan Administrator is vested with full discretionary authority to interpret, construe, and carry out the provisions of the Plan, and to render decisions on the administration of the Plan, including any factual and legal determinations as to whether an individual is eligible to be enrolled in and/or receive any benefit under the terms of this Plan. The name of the person designated as the Agent for Service of Legal Process is Cory Gibson, whose address is the same as the Employer's address. Service of Legal Process may also be made upon a Plan trustee or the Plan Administrator.

(h) *Spouse.* Spouse means a person of the same or opposite sex to whom you are legally married under the laws of the jurisdiction in which the marriage was entered into (as such laws existed at the time of marriage), regardless of whether the marriage would be recognized by the jurisdiction in which you currently reside. A common law marriage shall be considered to be a legal marriage if the common law marriage was validly entered into in a state that recognizes common law marriage. The Plan Administrator shall have the authority to determine whether a person is a Spouse, including the authority to request such documents as may be necessary, in its discretion, to establish the existence of a legal marriage (including the existence of a common law marriage). An individual will not be considered a "Spouse" for purposes of this Plan if (i) his/her marriage to you has been terminated by a court having jurisdiction over you or the individual or (ii) either party to the marriage is also lawfully married to another (third) person under the laws recognized by any state.

(i) *Dependent.* Dependent means, for purposes of the Health FSA only, the following:

(i) *Children Through Age Twenty-Six (26).* Your natural child, lawfully adopted child (including a child placed with you for adoption but for whom the adoption is not yet final), stepchild, or other child for whom you have obtained legal guardianship pursuant to a court order, until such child attains age twenty-six (26) (or until such child attains age eighteen (18) in the case of a legal guardianship). Children placed with you for adoption and children who are the subject of a Qualified Medical Child Support Order will also be considered Dependents.

(ii) *Disabled Children Above Age 26*. Your natural child, lawfully adopted child (including a child placed with you for adoption but for whom the adoption is not yet final), stepchild, or other child for whom you have obtained legal guardianship pursuant to a court order, who is unmarried and incapable of self-sustaining employment by reason of mental retardation or physical disability and for whom you are the major source of financial support, from the end of the calendar month in which the child attains age 26.

(iii) *Non-Children Dependents*. Any of your relatives who reside in your home, are claimed by you as a tax dependent, and meet the definition of a tax dependent under Code § 152.

(j) *Plan Year.* The Plan Year is the twelve (12) month period beginning every April 1 and ending the subsequent March 31, except that the Plan Year for the Health FSA and DCAP is September 1-August 31.

(2) Participation in the Plan

You will automatically become a Participant in the Plan on your plan entry date if you satisfy the eligibility conditions for the Plan. Once you become a Participant, you will continue to be a Participant until the eligibility conditions are no longer met. These requirements are explained in more detail below.

(a) *Eligibility Conditions.* To be eligible to participate in the Plan (i.e., to be an "Eligible Employee"), the following conditions must be met:

(i) *Employee.* You must be an individual employed by the Employer;

(ii) *Regularly Scheduled Hours per Week.* Your regularly scheduled workweek must ordinarily equal or exceed twenty (20) hours per week, except that if you are classified as a "substitute" employee (a category that includes, but is not limited to, substitute teachers, substitute bus drivers, substitute custodians, substitute food service, substitute aides, substitute secretaries) you must be regularly scheduled to work at least thirty (30) hours per week. For purposes of the Plan, this is considered to be "full-time"; and

(iii) *Not Excluded from Participation.* You must not be excluded from participation. You are excluded from participation if you are (A) covered under a collective bargaining agreement; (B) classified as a seasonal employee; (C) classified on the Employer's payroll records as a "leased" employee; or (D) for purposes of participating in this Plan (but not, unless otherwise provided, for purposes of participating on an after-tax basis in any underlying Benefit Package Option), an individual who is, with respect to the Employer, self-employed within the meaning of Section 401(c)(1) of the Code or is treated as a partner under Section 1372 of the Code.

(b) *Plan Entry Date.*

(i) *General Rule.* If you are an Eligible Employee, you will become a Participant on the first day of the month following date of hire.

If you enter the Plan pursuant to this Section (2) of this SPD, you are a Participant without regard to whether you elect to reduce your Compensation in order to purchase benefits under one (1) or more of the Pre-Tax Benefits and/or After-Tax Benefits.

EXAMPLE #1: You are hired as a full-time employee on October 15. You will be eligible to participate in the Plan on November 1. If you wish to participate in the Plan, you must make an Election to do so within thirty (30) days of November 1, (that is, by December 1).

If you do not return a completed Election form, or if your completed Election form is received after December 1, you will not be able to enter the Plan until the first day of the next Plan Year unless you experience an "Election change event".

(c) *Termination of Participation.* Once you become a Participant, you will continue to be a Participant as long as each of the eligibility conditions is met. If one or more of these conditions is not met, you will cease to be a Participant, unless a special rule applies. The special rules that might apply are summarized below.

(i) *Special Rule for Leaves of Absence.* If the number of hours that you are regularly scheduled to work each week falls below the minimum number required for you to participate in the Plan, you may still continue to participate in the Plan if you are on (A) a paid leave approved by the Employer; (B) unpaid leave under the Family and Medical Leave Act ("FMLA") if the FMLA is applicable to the Employer; or (C) unpaid leave through the end of the month.

(ii) *Special Rule for Military Service.* If you enter active service in the armed forces of any country, you will not be eligible to participate in the Plan unless your service is temporary active service of two (2) weeks or less.

(iii) *Special Rule for Certain Pre-Tax Benefits.* If you are participating in a Pre-Tax Benefit and your employment is terminated before the end of a pay period or the end of the month, your participation in the Plan may continue through the end of the pay period and/or the month (depending on the underlying Pre-Tax Benefit).

EXAMPLE: You participate in the Medical Plan. You are paid on the first (1st) and fifteenth (15th) of each month. You terminate employment on July 5. You will remain an Eligible Employee in the Plan for purposes of participating in the Medical Plan on a pre-tax basis through the end of the month.

(3) Pre-Tax Benefit Options – Participant Elections

To purchase benefits on a pre-tax basis through the Plan, you must elect to do so by completing and returning a salary reduction agreement to the Plan Administrator. This is known as an "Election." Once you have made an Election, you will not be able to change that Election until the next Plan Year, unless an exception applies. These rules are discussed in more detail below.

(a) *How to make an Election.* To make an Election, you must complete a salary reduction agreement and return the completed salary reduction agreement to the Plan Administrator. If you are changing an Election in the middle of a Plan Year, you may also be required to complete and return an Election change form. The Plan Administrator may require the salary reduction agreement or the Election change form to be completed and submitted in electronic form through the use of the Internet, an Intranet, a telephone system, or such other system as the Plan Administrator may prescribe.

(b) *When to make an Election.* An Election for the next Plan Year must be made during the Annual Enrollment Period for that Plan Year. The Annual Enrollment Period will be announced by the Plan Administrator each year. An Election change during the middle of a Plan Year must be made no later than thirty (30) days after the event that allows an Election change to be made, except that an Election change made in connection with certain HIPAA special enrollment rights may be made within sixty (60) days after the event as further described in (3)(d)(ii) below. If you are a new Participant in the Plan, an Election must be made no later than thirty (30) days after the date you entered the Plan.

(c) *Failure to make an Election.*

(i) *Failure to Make an Initial Election.* If you have never made an Election, you will not be able to purchase any benefits through the Plan on a pre-tax basis.

(ii) *Failure to Change Existing Election.* Once you have made an Election, a failure to complete a new salary reduction agreement for a subsequent Plan Year will be treated as a decision on your part to receive all of your Compensation in cash.

(d) *Election Changes.* An Election may not be changed in the middle of a Plan Year unless you qualify for one of the exceptions listed below. All Election changes must be approved by the Plan Administrator. In approving or denying an Election change, the Plan Administrator may rely on the terms of the Plan, IRS regulations, and informal guidance from the IRS.

You may change an Election in the middle of a Plan Year in the following circumstances (and subject to the other rules of the Plan):

(i) *Change in Status.* If there is a "change in status" and the Election change is consistent with the "change in status," then the following events may constitute a "change in status":

(A) A change in your marital status;

(B) A change in the number of your dependents;

(C) A change in the employment status of yourself, your Spouse, or your dependent. This may include starting a new job, leaving an old job, taking an unpaid leave of absence, or returning from an unpaid leave of absence. It may also include a change in the number of hours that you, your Spouse, or your dependent are regularly scheduled to work, but only if the change in hours affects your eligibility for benefits under the Plan, or any of the other Benefit Plans, or your Spouse's or dependent's eligibility under a benefit plan of their employer;

(D) One of your dependents satisfies, or ceases to satisfy, the eligibility requirements for a dependent under a Benefit Plan;

(E) A change in residence for yourself, your Spouse, or your dependent if it affects that person's eligibility for benefits; and/or

(F) You enroll in a Qualified Health Plan through an Exchange/Health Insurance Marketplace (the "Marketplace") established pursuant to the Patient Protection & Affordable Care Act by virtue of having become eligible for a special enrollment period in the Marketplace or by having enrolled during the Marketplace's annual open enrollment period. However, in order to make an Election change on this basis, you (and any Spouse and/or dependents who are covered through you) must enroll in the Qualified Health Plan and have such coverage take effect no later than the day immediately following the day that your coverage under the Medical Plan is terminated.

Whether an Election change is consistent with the "change in status" will be determined by the Plan Administrator in accordance with IRS regulations and prevailing IRS guidance.

(ii) *HIPAA Special Enrollment Rights.* Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), group health plans must provide a "special enrollment" period for certain individuals. These individuals include individuals who were eligible for coverage but who did not enroll due to other coverage and individuals who have become dependents through marriage, birth, or adoption. These individuals also include individuals who become eligible for

a state premium assistance subsidy under a Group Health Plan of the Employer from either Medicaid or a state's children's health insurance program (SCHIP). Similarly, individuals who lose eligibility for Medicaid or SCHIP coverage have special enrollment rights in the Plan. If you exercise your "special enrollment" rights under HIPAA, you may make an Election change to pay the cost of covering the individuals you enrolled. Unlike with the other Election change events, you have sixty (60) days to enroll an individual if the Election change event is a HIPAA special enrollment right related to eligibility for a state premium assistance subsidy or a loss of eligibility for Medicaid or SCHIP.

(iii) *Change in Coverage of Your Spouse or Dependent.* If there is a change in the coverage of your Spouse or your dependent and that coverage is obtained through the cafeteria plan of another employer, you may make a "corresponding" Election change. For this exception to apply, one (1) of the following conditions must be met: (A) The plan year of the other employer's cafeteria plan is different than the Plan Year of the Plan; or (B) the cafeteria plan of the other employer permits only those Election changes that are authorized under IRS regulations. The Plan Administrator will decide in its discretion and in accordance with prevailing IRS guidance whether a requested change is on account of, and corresponds with, the change made under the plan of the other employer.

EXAMPLE: You have elected to provide medical coverage for your family under the Employer's Medical Plan. Your Spouse is employed by a different employer. During open enrollment for the cafeteria plan of that employer, your Spouse elects "family coverage" under the medical plan of that employer. The plan year of that employer is different than the Plan Year of your Employer. Under this exception, you may discontinue your Election to pay for family coverage on a pre-tax basis through this Plan.

(iv) *Loss of Governmental/Educational Institution Group Health Coverage.* If you, your Spouse, or your dependent loses group health coverage and the coverage was sponsored by a governmental or educational institution, you may make an Election change to add coverage for the persons who are losing coverage. For purposes of this provision, group health coverage sponsored by a governmental or educational institution includes a state's children's health insurance program (SCHIP) under Title XXI of the Social Security Act, a medical care program of an Indian Tribal government or a tribal organization, a state health benefits risk pool, or a foreign government health plan.

(v) *"Significant" Curtailment in Coverage.*

(A) *Without Loss of Coverage.* If coverage under a plan is "significantly curtailed," but not lost, you may change your Election to elect coverage under another benefit option that provides similar coverage. Coverage under a plan is "significantly curtailed" only if there is an overall reduction in the coverage provided to participants in the plan.

(B) *With Loss of Coverage.* If coverage under a plan is "significantly curtailed" and that curtailment constitutes a "loss of coverage" for you, your Spouse, or your dependent, you may change your Election to elect coverage under another benefit option that provides similar coverage. If no similar benefit option is available, you may elect to drop coverage. For purposes of this provision, a "loss of coverage" means a complete loss of coverage under the benefit option. This includes the elimination of a benefit option, the loss of coverage under an option due to an individual reaching an overall lifetime or annual coverage limit, a substantial decrease in the medical care providers available under the option, or a reduction in the benefits for a specific type of medical condition or treatment for which you, your Spouse, or your dependent is currently receiving treatment.

(C) *Determinations to be Made by the Plan Administrator.* The Plan Administrator will decide in its discretion, and in accordance with prevailing IRS guidance, whether a curtailment is "significant," whether a curtailment represents a "loss of coverage" with respect to a particular individual, and whether a substitute benefit option provides "similar coverage."

(vi) *Addition or Improvement of a Benefit Option.* If a benefit option is added in the middle of a Plan Year or if coverage under an existing benefit option is significantly improved, you may make an Election change to add that option.

(vii) *FMLA Leave.* If you take a leave of absence under the FMLA, you may change your Election for coverage under a Group Health Plan. You may also be able to change your Election under the "change in status" exception discussed above.

(viii) *To Comply with a Judgment, Decree, or Order.* If you are required to provide medical coverage for a dependent child pursuant to a judgment, decree, or order, you may change your Election to pay for the increased cost of the coverage. If you are already providing coverage and a judgment, decree, or order requires someone else to provide coverage, you may change your Election to reflect the decreased cost of coverage. *However*, before you are allowed to drop coverage, you may be required to provide proof that other coverage for the child is actually being provided.

(ix) *Entitlement to Medicare/Medicaid.* If you, your Spouse, or your dependent becomes entitled to Medicare or Medicaid, you may change your Election to reflect the decreased cost of coverage under the Employer's Group Health Plan. If you, your Spouse, or your dependent loses your/their entitlement to Medicare or Medicaid, you may increase your Election to reflect the increased cost of coverage under the Employer's Group Health Plan.

(x) *Significant Change in Cost of Coverage.* If your share of the premium for coverage under a benefit option increases by a significant amount, you may increase your Election to reflect the increased cost or you may elect to be covered under another benefit option (if any) providing similar coverage. If similar coverage is not available, you may drop your coverage all together.

If your share of the premium for coverage under a benefit option decreases by a significant amount, you may decrease your Election by a corresponding amount or, if you are not currently enrolled in that benefit option, you may elect to become covered under that benefit option.

Whether there has been a "significant" change in cost and whether another benefit option provides "similar coverage" will be decided by the Plan Administrator in its discretion and in accordance with prevailing IRS guidance.

In addition to the Election changes, which you may make in the middle of a Plan Year, as summarized above, the Plan Administrator may automatically change the amount of your Election in the middle of a Plan Year if there is an "insignificant" change in the cost of the coverage you have elected. Whether there has been an "insignificant" change in cost will be decided by the Plan Administrator in its discretion and in accordance with prevailing IRS guidance.

(e) *Effective Date of Elections.*

(i) *Election Made During Annual Enrollment Period.* An Election made during the Annual Enrollment Period will be given effect as of the first day of the next Plan Year.

(ii) *Election Made in the Middle of a Plan Year.* An Election made in the middle of a Plan Year will be given effect as of the earliest administratively practicable date after a completed Election change form and salary reduction agreement are received by the Plan Administrator. This includes both Election changes and the initial Elections made by new Participants. Under IRS regulations, Elections cannot be given retroactive effect. For example, although you can use pre-tax dollars to pay for future coverage, you cannot use pre-tax dollars to pay for coverage that has already been provided. The only exception to this prohibition is for newborn children and newly adopted dependents who are enrolled in a Group Health Plan pursuant to HIPAA "special enrollment" rights. Coverage that is retroactive to the date of their birth or adoption may be paid for on a pre-tax basis.

(f) *Special Rule for Former Participants Rehired Within Thirty (30) Days of Termination.* If you are rehired within thirty (30) days after the date on which your employment was terminated, you will be reinstated in the Plan with the same Elections you had before your employment was terminated unless (i) you would be permitted to make an Election change for some reason other than the change in your employment with the Employer or (ii) the Plan Year ended on or after the date your employment was terminated, but before the date you were rehired.

(g) *Special Rule for Health FSAs.* You may *not* change your Election under the Health FSA in the middle of a Plan Year except as follows:

(i) You may begin to participate in the Health FSA if you are eligible, provided you are permitted to make an Election change under the rules summarized in Section (3)(d) above;

(ii) You may increase your Election as long as you do not exceed the maximum Election amount permitted under the Health FSA and provided you are permitted to make an Election change under the rules summarized in Section (3)(d) above; or

(iii) You may decrease your Election, provided you are permitted to make an Election change under the rules summarized in Section (3)(d) above; however, you may not reduce your Election amount below the total amount you have already been reimbursed.

EXAMPLE: During the Annual Enrollment Period, you make an Election of $1,200 for your Health FSA for the Plan Year. To pay for this benefit, your salary is reduced by $100 per month. Suppose that after three (3) months, you have contributed a total of $300 into your Health FSA, you have been reimbursed $400, and you experience a qualifying Election change event. You may change your Election for the Plan Year to any amount equal to or greater than $400.

Continuing with the above example, suppose you change your Election amount to $600 instead of $1,200. Because you have already been reimbursed $400, only $200 will be available to you for reimbursement through the end of the Plan Year.

Except as set forth above, an Election with respect to the Health FSA may not be changed during the Plan Year once it has been made.

(4) After-Tax Benefit Option - Participant Elections

You may make and/or change your Elections with respect to an After-Tax Benefit at any time in accordance with the rules and procedures established by the Plan Administrator. Any such Election change will take effect on the earliest administratively practicable date after the request to change an after-tax Election is received by the Plan Administrator.

(5) Medical Plan

The Employer maintains a Medical Plan that pays benefits pursuant to the terms and conditions of a group contract with Blue Cross Blue Shield of Kansas ("BCBS"), 1133 SW Topeka Boulevard, Topeka, Kansas 66629-0001.

(a) *Type of Plan.* The Medical Plan is a group health plan. The Medical Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility/Plan Entry Dates.* The eligibility conditions and the Medical Plan entry dates are the same as those for the Plan.

(c) *Enrollment in the Plan.* **To become a Participant in the Medical Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Medical Plan entry date. **If you do not elect to participate in the Medical Plan, you will not receive any benefits under the Medical Plan.**

(i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you will not be allowed to enroll in the Medical Plan until the next open enrollment period and your enrollment will not take effect until the anniversary date of the BCBS group contract. The same rule applies if you fail to enroll your dependents (including your Spouse) when you are first eligible to do so. This rule does not apply, however, if you are entitled to HIPAA "Special Enrollment" rights.

(ii) *HIPAA "Special Enrollment" Rights.* If you are declining enrollment in the Medical Plan for yourself or your dependents because of other health insurance coverage and that other coverage is subsequently lost, you may be able to enroll yourself and/or your dependents in the Medical Plan if you request enrollment within thirty (30) days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption. Finally, if you become eligible for a state premium assistance subsidy under a Group Health Plan of the Employer from either Medicaid or a state's children's health insurance program (SCHIP), you may be able to enroll yourself and/or your dependents in the Medical Plan if you request enrollment within sixty (60) days after you or your dependents become eligible for such assistance. Similarly, if you lose eligibility for Medicaid or SCHIP coverage, you have special enrollment rights in the Plan, provided you request enrollment within sixty (60) days after you or your dependents lose eligibility for Medicaid or SCHIP coverage.

(d) *Plan Benefits.* If you elect to participate in the Medical Plan, benefits will be provided by the Employer pursuant to the terms and conditions of the group contract between the Employer and BCBS. This Medical Plan provides you and/or your dependents with comprehensive medical coverage. BCBS has prepared materials which explain the benefits under this Medical Plan in detail. If you have not received these materials from BCBS, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.

(e) *Obligation to Pay Benefits.* BCBS is solely obligated to pay for medical benefits provided under the BCBS group contract. The Employer makes no promise, and will have no obligation, to provide or pay for any benefits under the group contract.

(f) *Premiums.* The monthly premiums for insurance coverage under the Medical Plan are determined by BCBS and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Premiums may be paid on a pre-tax basis through the Plan.

(g) *Medical Treatment.* The Medical Plan does not provide medical treatment or give medical advice. **It is your responsibility, in consultation with the physicians of your choice, to get appropriate medical treatment**. The fact that some expense may not be eligible for reimbursement by the Medical Plan does not mean that you or your dependents should not have that treatment.

(h) *Claims Procedures.* In the event you have a claim for benefits under the Medical Plan, you should follow the procedures outlined in the materials prepared by BCBS, as applicable. The Plan Administrator, upon your request, will assist you in making these claims. BCBS has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the applicable group contract,

(i) *Explanation of Benefits*. You will receive an explanation of benefits (EOB) under the Medical Plan at your primary residence (as provided to the Claims Administrator, i.e., the insurance company for fully insured plans or third-party administrator for self-funded plans). If your covered Spouse or dependent does not wish for an EOB to be provided at this address, he/she will need to contact the Claims Administrator and provide an alternate address.

(j) *Termination of Coverage.* Your participation in the Medical Plan ends on whichever of the following dates occurs first:

(i) The last effective date of coverage – as specified by the insurance group contract – following your termination of employment with the Employer;

(ii) The date on which your election to participate expires;

(iii) The end of a period for which a required contribution by you was last paid, taking into account any grace periods required by law;

(iv) The last effective date of coverage – as specified by the insurance group contract – following the date on which you cease to be an Eligible Employee; or

(v) The day the Employer terminates the Medical Plan.

Your coverage for benefits under the Medical Plan ends with the termination of your participation. However, you may, in some circumstances, be entitled to purchase COBRA continuation coverage. COBRA continuation coverage is discussed in a separate section of this SPD.

(6) Dental Plan

The Employer maintains a Dental Plan that pays benefits under a group contract with Delta Dental of Kansas, Inc. ("Delta Dental"), P.O. Box 789769, Wichita, KS 67278.

(a) *Type of Plan.* The Dental Plan is a group health plan. The Dental Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility/Plan Entry Dates.* The eligibility conditions and the Dental Plan entry dates are the same as those for the Plan.

(c) *Enrollment in the Plan.* **To become a Participant in the Dental Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Dental Plan entry date. **If you do not elect to participate in the Dental Plan, you will not receive any benefits under the Dental Plan.**

(i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you will not be allowed to enroll in the Dental Plan until the next open enrollment period and your enrollment will not take effect until the anniversary date of the Delta Dental group contract. The same rule applies if you fail to enroll your dependents (including your Spouse) when you are first eligible to do so. This rule does not apply, however, if you are entitled to HIPAA "Special Enrollment" rights.

(d) *Plan Benefits.* If you elect to participate in the Dental Plan, benefits will be provided by the Employer pursuant to the terms and conditions of a group contract between the Employer and Delta Dental. This Dental Plan provides you and/or your dependents with comprehensive dental coverage. Delta Dental has prepared materials which explain the benefits under this Dental Plan in detail. If you have not received these materials from Delta Dental, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.

(e) *Obligation to Pay Benefits.* Delta Dental is solely obligated to pay for the benefits provided under the Delta Dental group contract. The Employer makes no promise and will have no obligation to provide or pay for benefits under the group contract.

(f) *Premiums.* The monthly premiums for insurance coverage under the Dental Plan are determined by Delta Dental and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Premiums may be paid on a pre-tax basis through the Plan.

(g) *Dental Treatment.* The Dental Plan does not provide dental treatment or give dental advice. **It is your responsibility, in consultation with the dentists of your choice, to get appropriate dental treatment**. The fact that some expense may not be eligible for reimbursement by the Dental Plan does not mean that you or your dependents should not have that treatment.

(h) *Claims Procedures.* In the event you have a claim for benefits under the Dental Plan, you should follow the procedures outlined in the materials prepared by Delta Dental, as applicable. The Plan Administrator, upon your request, will assist you in making these claims. Delta Dental has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the group contract.

(i) *Explanation of Benefits.* You will receive an explanation of benefits (EOB) under the Dental Plan at your primary residence (as provided to the Claims Administrator, i.e., the insurance company for fully insured plans or third-party administrator for self-funded plans). If your covered Spouse or dependent does not wish for an EOB to be provided at this address, he/she will need to contact the claims administrator and provide an alternate address.

(j) *Termination of Coverage.* Your participation in the Dental Plan ends on whichever of the following dates occurs first:

(i) The last effective date of coverage – as specified by the insurance group contract – following your termination of employment with the Employer;

(ii) The date on which your election to participate expires;

(iii) The end of a period for which a required contribution by you was last paid, taking into account any grace periods required by law;

(iv) The last effective date of coverage – as specified by the insurance group contract – following the date on which you cease to be an Eligible Employee; or

(v) The day the Employer terminates the Dental Plan.

Your coverage for benefits under the Dental Plan ends with the termination of your participation. However, you may, in some circumstances, be entitled to purchase COBRA continuation coverage. COBRA continuation coverage is discussed in a separate section of this SPD.

(7) Health Flexible Spending Account

The Employer maintains a Health FSA that pays benefits out of the Employer's general assets.

(a) *Type of Plan.* The Health FSA is a self-funded group health plan. The Health FSA is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility/Plan Entry Date.* The eligibility conditions and the Health FSA entry date are the same as those for the Plan.

(c) *Election to Participate in the Plan.* To become a Participant in the Health FSA, you must complete and return the form or forms provided by the Plan Administrator. **If you do not elect to participate in the Health FSA, the Employer will not provide you with any benefits under the Health FSA.**

(i) *Failure to Enroll When First Eligible.* As a general rule, if you fail to enroll when you are first eligible to do so, you will not be allowed to enroll in the Health FSA until the next Annual Enrollment Period, in which case your enrollment will not take effect until the first day of the next Plan Year. However, if you experience an event that would allow an Election change under the terms of the Plan (see Section (3)(d) of this SPD), you may enroll in the Health FSA in the middle of the Plan Year.

(ii) *Election Changes Once Enrolled in the Health FSA.* Once you elect to participate in the Health FSA, you will be permitted to change your Election after the beginning of the Plan Year if you experience an event that would allow an Election change under the terms of the Plan (see Section (3)(d) of this SPD). In general, you may begin participation or increase your Election amount for the remainder of the Plan Year. You are also permitted to decrease your Election amount provided, however, that the Election amount is not less than the amount you have already been reimbursed.

To determine the amount that you may be reimbursed for the remainder of the Plan Year, you should subtract the amount you have already been reimbursed from the new Election amount.

EXAMPLE: During the Annual Enrollment Period, you elect $1,200 for the Plan Year. You make monthly contributions of $100 per month for six (6) months (totaling $600) and you are reimbursed $900 during that 6-month period. Suppose you experience an Election change event which would permit you to change your Election for the remaining six (6) months of the Plan Year. You then request to *decrease* your election to $600. You will not be permitted to make this change in your Election amount. This is because your total reimbursements to date (i.e., $900) is greater than the new Election amount (i.e., $600). You could, however, decrease your Election to $1,000 for the remainder of the Plan Year. This is because your new Election amount is greater than the amount you have already been reimbursed (i.e., $900). In the remaining six (6) months of the year, you will be able to receive $100 in future reimbursements.

(d) *Special Rules Relating to FMLA Leave.* If you are a Participant in the Health FSA and you are taking or returning from FMLA leave, the following special rules apply to your participation in the Health FSA:

(i) *Taking FMLA Leave.* You may continue to participate in the Health FSA after you begin your FMLA leave by continuing to pay the applicable premium while you are on leave or by making such other arrangements for the payment of the applicable premiums as may be permitted under the Plan (see Section (17)(b) of this SPD). You may also choose to discontinue your participation in the Health FSA once you begin your FMLA leave.

(ii) *Returning From FMLA Leave.* If you discontinued your participation in the Health FSA when you began your FMLA leave, you may choose to participate again once you return to work from your FMLA leave. If you want to resume your participation at the same coverage level that was in effect before your FMLA leave, you will be required to pay the premiums that would have been due while you were on FMLA leave. If you do not want to make up the missed premiums, you may instead choose to resume coverage at a reduced level. In this event, the amount of coverage that you elected will be reduced by the percentage of the Plan Year that you were on FMLA leave. For example, if you had elected $1,200 for the Plan Year and were on FMLA for two months, your annual Election would be reduced to $1,000 under this alternative.

(e) *Effective Date of Election.* If you elect to participate in the Health FSA, your Election will take effect and you will become a Participant as follows:

(i) *Election Made During Annual Enrollment Period.* If you elect to participate during the Annual Enrollment Period for the Plan, your Election will take effect on the first day of the next Plan Year. In other words, you will become a Participant as of the first day of the next Plan Year.

(ii) *Election Made by A Newly Eligible Employee.* If you elect to participate within thirty (30) days after you first become eligible to participate in this Health FSA, your Election will take effect on the first day of the month following the receipt of your completed Election form by the Plan Administrator. If your Election form is received on the first day of the month, you will become a Participant on that same day.

EXAMPLE: You begin working as a full-time employee on October 15. You will be eligible to participate in the Health FSA on November 1. If you wish to participate in the Health FSA, you must make an Election to do so within thirty (30) days of November 1, (that is, by December 1).

If you do not return a completed Election form, or if your completed Election form is received after December 1, you will not be able to enter the Health FSA until the first day of the next Plan Year unless you experience an "Election change event" (see below).

(iii) *Election Made Following an Election Change Event.* If you elect to participate within thirty (30) days after an event that would allow you to make an Election change under the Plan (see Section (3)(d) of this SPD), your Election will take effect on the first day of the month following the receipt of your completed Election form by the Plan Administrator. If your Election form is received on the first day of the month, you will become a Participant on that same day.

EXAMPLE: During the Annual Enrollment Period, you did not elect to participate in the Plan. On March 15, your child is born. This is a "change in status" which allows you to make an Election change under the Plan. You may elect to participate in the Plan if you do so within thirty (30) days after March 15, (that is, by April 14). If you do not elect to enter the Health FSA within thirty (30) days after this "change in status," you will not have a second opportunity to enter the Health FSA until the first day of the next Plan Year unless you experience a second Election change event.

(iv) *Automatic Election if Carryover Amount Exists*. If you do not elect to participate in the Health FSA for the Plan Year, but you have a Carryover Amount (defined below) from a prior Plan Year, you will nevertheless be automatically re-enrolled in the Health FSA with a deemed election of zero (0) dollars. The sole purpose of the election of zero (0) dollars is to allow you the opportunity to spend the Carryover Amount. This special rule for Carryover Amounts shall apply unless you have affirmatively elected to forfeit the Carryover Amount on a form provided by either the Plan Administrator or Claims Administrator.

(f) *Plan Benefits.* If you elect to participate in the Health FSA, you must elect the amount by which you want the Employer to reduce your salary for the Plan Year. To determine how much you should reduce your salary for medical reimbursement benefits, you should estimate the amount of medical and dental expenses you expect to have for the Plan Year in which your health or dental insurance will not cover. When you incur uninsured medical or dental expenses, the Plan Administrator will reimburse you for those expenses. The amount of salary you reduce for these medical or dental expenses is not subject to income tax or FICA.

EXAMPLE: You elect to reduce your salary by $1,200 for the Plan Year. You have $300 in carryover funds from the prior Plan Year. Therefore, 1,500 is your maximum reimbursement for uninsured medical expenses incurred for that Plan Year.

If you do not incur uninsured medical expenses for the Plan Year equal to the maximum reimbursement amount, plus any amount allowed as a "carryover" from a prior year, you will lose the unused portion up to the maximum Carryover Amount (defined in (g)(i) below).

EXAMPLE: Assume you elect to reduce your salary by $1,200 for medical expenses and you have a Carryover Amount of $300 from the prior Plan Year, for a total of $1,500 in funds. You incur only $500 of uninsured expenses for the current Plan Year. Although you will be entitled to carryover $500 in funds to the subsequent Plan Year, as required by IRS regulations, you will forfeit the remaining $500. This example illustrates the importance of carefully estimating your uninsured medical expenses for the Plan Year.

If the Employer determines after the claims Run-Out Period and after processing all pending claims and all Carryover Amounts that the total premiums paid by all participants in the Health FSA exceed the total reimbursements paid out, the Plan will have a surplus. Such surplus will be used to offset reasonable administrative costs. Any

surplus remaining after such costs are paid will be used to reduce the required premiums in the following Plan Year. If you are a participant in the Health FSA on the date of the first payroll following the date on which the amount of surplus has been determined, you will receive a reduction in the cost of your premium, known as a "premium holiday."

If the Health FSA is terminated by the Employer before or at the end of the Plan Year, then the Employer will determine whether or not there is a surplus. There is a surplus if the total contributions from all Participants exceed the total Health FSA reimbursements. This determination will not be made until after the claims Run-Out Period and after all pending claims have been processed. The Employer will use the surplus, if any, to offset reasonable administrative costs. Any surplus remaining after reasonable administrative costs have been paid shall be distributed to all individuals who were participating in the Health FSA on the date of the Plan's termination. The amount of remaining surplus will be divided by the number of participants entitled to the distribution in order to determine each person's share. In no case will the surplus be allocated to you based directly or indirectly on your claims experience or on the amount of your annual election.

(g) *Maximum Benefit Amount.* Under the Health FSA, if you or your dependents incur a "qualified medical expense" for which you submit a timely claim for reimbursement, you will receive a reimbursement for the portion of that expense that is not covered by medical or dental insurance; however, your reimbursements may not exceed the maximum reimbursement amount.

(i) *Maximum Reimbursement Amount – General Rule.* The maximum reimbursement amount for a Plan Year may not exceed the total amount that you have elected to contribute to the Health FSA for that Plan Year.

(ii) *Limits on Contributions to a Health FSA.* The amount that you elect to contribute to the Health FSA for a Plan Year may not exceed the dollar limit that is established each year by the Employer. That dollar limit, in turn, may not exceed the dollar limit established by Congress in the Code, as adjusted by the IRS for periodic cost-of-living increases. The dollar limit established by the Employer will be communicated in the enrollment materials for the Health FSA. The Plan Administrator will also provide information about this dollar limit upon request.

(iii) *Maximum Reimbursement Amount – Run-Out Periods.* A claim that is incurred during the previous Plan Year and which is submitted for reimbursement during the Plan's Run-Out Period will count against the maximum reimbursement amount for the previous Plan Year and not the Plan Year during which reimbursement is made.

(iv) *Special Carryover Rule.* The maximum reimbursement amount for the current Plan Year, as described above, may be increased by any Carryover Amount you might have. A Carryover Amount is the amount, if any, remaining in your Health FSA account from the previous Plan Year as determined on the last day of the Run-

Out Period for that Plan Year. A Carryover Amount is limited to no more than $500. Any amount remaining in excess of the Carryover Amount must be forfeited in accordance with IRS rules.

(v) *Order of Reimbursement*. Reimbursements during the Run-Out Period for current-year claims will be made from current-year amounts in order to maximize the potential Carryover Amount, unless you specifically request otherwise and the Plan Administrator permits such alternative reimbursement ordering.

(h) *Qualified Medical Expenses.* The "qualified medical expenses" for which you (or your Spouse or Dependent) are entitled to reimbursement under the Health FSA are generally those medical expenses that are tax deductible under Section 213(d) of the Internal Revenue Code and for which you have not otherwise been reimbursed through insurance or any other means. Typical expenses include, but are not limited to:

(i) Deductibles and copayment amounts you pay under your medical or dental or vision care coverage;

(ii) Medical, dental and/or vision care expenses in excess of usual, reasonable and customary rates; and

(iii) Any other Code § 213(d) medical, dental, or vision expenses not reimbursed by insurance; provided, however, over-the-counter drugs or medicine (other than insulin) that are not purchased pursuant to a prescription are not eligible for reimbursement as "qualified medical expenses."

The Health FSA does not reimburse for amounts paid to obtain other health insurance coverage. The Health FSA will only reimburse you for qualified medical expenses incurred while you are a Participant in the Health FSA. Under IRS rules, a qualified medical expense is generally considered to be "incurred" when the treatment is provided and not when you are billed for the treatment or when the treatment is paid for.

Typical expenses <u>not</u> eligible for reimbursement by the Health FSA include, but are not limited to:

(i) Those reimbursed through any other policy or plan, including Medicare or other federal programs;

(ii) Those incurred before you enroll in the Health FSA;

(iii) Those incurred in any year other than the year for which Health FSA contributions are made;

(iv) Those claimed as a deduction or credit for federal income tax purposes; and

(v) Those the IRS would not allow as deductions for federal income tax purposes, except for certain over-the-counter drugs.

(i) *Run-Out Period.* "Run-Out Period" means the period that begins at the close of the Plan Year and ends on the September 30 immediately following the close of the Plan Year. Eligible expenses must be submitted for reimbursement before the end of the Run-Out Period.

(j) *Electronic Payment Card.* The Employer permits the use of an electronic payment card, such as a debit card, to pay for Qualified Medical Expenses. The electronic payment card may only be used at merchants and service providers which are authorized by the Employer.

(k) *How to Submit a Claim.*

(i) *Claims Forms.* Except as provided in (ii) below, in the event you have a claim for benefits under the Health FSA, you must submit a claim using the claims form that will be provided to you by the Plan Administrator and following the instructions on that form. The Claims Administrator may require you to provide such information as may reasonably be required to process the claims, including, but not limited to, the following:

(A) The amount, date incurred and nature of each expense;

(B) The name of the person, organization or entity with whom the expense was incurred;

(C) The name of the person for whom the expense was incurred;

(D) The amount (if any) recovered under any insurance arrangement or other plan, with respect to the expense; and

(E) A statement that the expense (or portion thereof for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any other health plan coverage.

(ii) *Electronic Payment Card.* If the Employer permits the use of an electronic payment card, such as a debit card, you may be able to access your Health FSA through the use of such card, provided that the claim is properly adjudicated. If your funds are accessible by an electronic payment card, you must comply with the substantiation procedures in accordance with Rev. Rul. 2003-43 and other IRS guidance. Under those procedures, some payments with your electronic payment card may be automatically substantiated by this Health FSA; other payments may require further substantiation by you to the Health FSA. Please note that, if you present your electronic payment card as payment for a medical expense and it is denied at the point-of-sale (i.e., when the service or item is provided), that denial of payment will *not* constitute an initial claim denial under these procedures.

(l) *Claims Administrator.* Surency will act as Claims Administrator with respect to any claim for benefits under this Health FSA. Surency has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the Surency Benefit Description.

(m) *Timing of Claims.* Subject to the Special Carryover Rule, you may submit your claim for benefits under the Health FSA during the Plan Year in which the expenses are incurred or within the Run-Out Period following the close of the Plan Year. If you terminate your participation in the Health FSA or if the Employer terminates the Health FSA, you must submit your claim for reimbursement for that Plan Year no later than thirty (30) days after the date of your termination or no later than thirty (30) days after the date the Employer terminates the Health FSA, respectively. For example, if you terminate employment with the Employer on July 1 of a particular Plan Year, you must submit your claim for reimbursement no later than July 31 of that Plan Year to receive reimbursement for expenses covered by the Plan which you incurred prior to that July 1.

(n) *Time Frame for Deciding Claims.* If any claim for benefits under this Health FSA is denied, in whole or in part, then the Claims Administrator will promptly furnish you, within thirty (30) days of receipt of the claim, written notice:

(i) Setting forth the reason for the denial;

(ii) Making reference to pertinent Health FSA provisions upon which the denial is based;

(iii) Describing any additional material or information which is necessary and why;

(iv) Referencing any internal rule, guideline, or protocol, or similar criterion relied upon in making the adverse determination (if applicable); and

(v) Explaining the claim review procedure set forth herein.

(o) *Extension of Time Frame for Deciding Claims.* The Claims Administrator may seek one extension of up to fifteen (15) days in order to make the benefit determination. The extension must be sought due to matters beyond the control of the Plan. You will be notified of the extension prior to the expiration of the initial 30-day period. If the extension is due to your failure to submit information necessary to decide the claim, the notice of extension shall specifically describe the required information and give you at least forty-five (45) days from receipt of the notice to provide the specified information. The period for making the benefit determination shall be tolled from the time the notification of extension is sent until the date on which you respond to the request for information.

(p) *Appealing a Claim Denial.* If your claim is denied, in whole or in part, you have one hundred eighty (180) days to submit an appeal. You may, upon request and free of charge, examine all pertinent documents and may submit issues and comments in writing.

(q) *Time Frame for Deciding Appeal.* The Plan Administrator shall render a decision on review no later than sixty (60) days after receipt of your request for review unless special circumstances require an extension of time (not to exceed sixty (60) days from the date of the initial 60-day period). You will be furnished with written notice of any such extension.

(r) *Decision on Appeal.* In conducting the review, no deference will be given to the initial adverse determination and a plan fiduciary, other than the one who originally decided the claim (or the person's subordinate), will make the determination upon appeal. The decision on review shall be in writing. If the claim is once again denied, in whole or in part, then the notification shall (i) state the reason for the decision, (ii) refer to the Health FSA provisions upon which it is based, (iii) state your right to receive (upon request and free of charge) reasonable access to, and copies of, all relevant information, and (iv) describe any voluntary appeals procedures.

(s) *Payment of Claims.* Approved claims will be paid directly to you. No claims will be paid to the provider of any services. Prior to making any payment of benefits under the Health FSA, Surency (or the Plan Administrator) may require you to provide such information and complete appropriate documents or forms necessary for the proper administration of the Plan. Surency and/or the Plan Administrator may rely upon all such information furnished to it, including your current mailing address. Furthermore, Surency (or the Plan Administrator), prior to making payments under the Plan, may require you to file all appropriate claims and requests for payment from any other plan or plans maintained by the Employer, including requests for payment with any insurance carrier which has the responsibility for making any benefit payments under any plans maintained by the Employer.

(t) *Termination of Coverage.* Your participation in the Health FSA ends on whichever of the following dates occurs first:

(i) The date that you terminate your employment with the Employer;

(ii) The date in which your election to participate expires;

(iii) The end of a period in which you last paid a required contribution; or

(iv) The date the Employer terminates the Health FSA.

Your coverage for benefits under the Health FSA ends with the termination of your participation. However, you may, in some circumstances, be entitled to purchase COBRA continuation coverage. COBRA continuation coverage is discussed in a separate section of this SPD.

(u) *Qualified Reservist Distributions (QRDs).* A "qualified reservist distribution" is a distribution of all or a portion of your account balance if you are called to active military service, provided the call to service is for a period of one hundred eighty (180) days or more or for an indefinite period of time.

(i) *Amount of QRD*. Unless a lesser amount is specifically requested, the QRD will be the total of your contributions as of the date of the approval of the QRD request minus the amount of any Qualified Medical Expense reimbursements received as of the date of the request for the QRD.

(ii) *Timeframe for Requesting a QRD*. You must request a QRD on or after the date you are called to active military service and prior to the end of the Run-Out Period immediately following the end of the Plan Year in which you are called to service.

(iii) *Timeframe for Claims Administrator to Respond to a QRD Request*. The Claims Administrator shall respond to any timely request for a QRD within sixty (60) days of the date it receives the request, including providing payment of the distribution within such time frame if the request is approved. If the request is denied, the Claims Administrator shall follow the claims procedures set forth above in this Health FSA section of the SPD, except that the time frame set forth in (n) above is sixty (60) days instead of thirty (30) days.

(iv) *Eligible Claims*. If you request a QRD, you forfeit the right to receive reimbursements for Qualified Medical Expenses incurred after the date of your last day of active employment. You will be reimbursed for Qualified Medical Expenses properly submitted for reimbursement prior to the end of the Run-Out Period immediately following the end of the Plan Year and incurred on or prior to the last day of active employment or if later, the date of your QRD request, provided that the total dollar amount of such claims does not exceed the amount of your election minus the sum of your QRD and prior reimbursements received for the Plan Year.

(v) *No Penalty on QRD*. The QRD will not be subject to a distribution penalty. The amount of the QRD, however, will be included in your gross wages for the Plan Year in which the distribution is made, as required by the Internal Revenue Code and applicable IRS guidance.

(8) Dependent Care Assistance Plan

The Employer maintains a DCAP that pays benefits out of the Employer's general assets.

(a) *Type of Plan.* The DCAP is a Code Section 129 dependent care assistance plan. The DCAP is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility/Plan Entry Date.* The eligibility conditions and the plan entry date are the same as those for the Plan.

(c) *Election to Participate in the Plan.* To become a Participant in the DCAP, you must complete and return the form or forms provided by the Plan Administrator. **If you do not elect to participate in the DCAP, the Employer will not provide you with any benefits under the DCAP.**

(d) *Effective Date of Election.* If you elect to participate in the DCAP, your Election will take effect and you will become a Participant as follows:

(i) *Election Made During Annual Enrollment Period.* If you elect to participate during the Annual Enrollment Period for the Plan, your Election will take effect on the first day of the next Plan Year. In other words, you will become a participant as of the first day of the next plan year.

(ii) *Election Made by A Newly Eligible Employee.* If you elect to participate within thirty (30) days after you first become eligible to participate in this DCAP, your Election will take effect on the first day of the month following the receipt of your completed Election form by the Plan Administrator. If your Election form is received on the first day of the month, you will become a Participant on that same day.

EXAMPLE: You begin working as a full-time employee on November 15. You will be eligible to participate in the DCAP on December 1. If you wish to participate in the DCAP, you must make an Election to do so within thirty (30) days of December 1, (that is, by December 31).

If you do not return a completed Election form, or if your completed Election form is received after December 31, you will not be able to enter the DCAP until the first day of the next Plan Year unless you experience an "Election change event" (see below).

(e) *Election Made Following an Election Change Event.* If you elect to participate within thirty (30) days after an event that would allow you to make an Election change under the Plan (see Section (3)(d) of this SPD), your Election will take effect on the first day of the month following the receipt of your completed Election form by the Plan Administrator. If your Election form is received on the first day of the month, you will become a Participant on that same day.

EXAMPLE: During the Annual Enrollment Period, you did not elect to participate in the Plan. On March 15, your Spouse begins a full-time job. This is a "change in status" which allows you to make an Election change under the Plan. You may elect to participate in the Plan if you do so within thirty (30) days after March 15, (that is, by April 14). If you do not elect to enter the DCAP within thirty (30) days after this "change in status," you will not have a second opportunity to enter the DCAP until the first day of the next Plan Year unless you experience a second Election change event.

(f) *Plan Benefits.* If you elect to participate in the DCAP, you must elect the amount by which you want the Employer to reduce your salary for the Plan Year. Under the DCAP, the maximum amount of reimbursement you may receive for a Plan Year is limited to the actual amount of your salary reduction for the Plan Year.

(g) *Maximum Benefit Amount.* The benefits you receive under this DCAP may not exceed the maximum amount specified in the Internal Revenue Code. The maximum amount specified in the Internal Revenue Code is $5,000 (or $2,500 if you are a married person filing a separate return) *per calendar year* or, if less, your "earned income limitation." The maximum benefit amount *per Plan Year* is also $5,000 (or $2,500 if you are a married person filing a separate return) or, if less, your "earned income limitation." The "earned income limitation" is your earned income, if you are not married. If you are married, the earned income limitation is the lesser of your earned income or your Spouse's earned income.

(h) *IRS "Use It or Lose It" Requirement.* You should carefully evaluate the amount of your salary reduction for dependent care expenses. ***If your dependent care expenses are less than the amount by which you have reduced your salary for the Plan Year, you will forfeit the excess amount.*** This is an IRS requirement.

(i) *Election Changes.* Once you make an Election to participate in this DCAP, that Election may not be changed in the middle of the Plan Year, either as to your participation in the Plan or as to the dollar amount you elected, unless an Election change is permitted under the terms of the Plan (see Section (3)(d) of this SPD).

(j) *Federal Income Tax Considerations.* You may be able to claim a Dependent Care Tax Credit on your federal income tax return for your dependent care expenses. The availability of this credit depends on the number of dependents you have and your gross income. More information about the federal Dependent Care Tax Credit may be found in IRS Publication No. 503. ***You may not claim a credit on your federal income tax return for any dependent care expenses for which you have been reimbursed by the DCAP***. In many cases, you may save more money by receiving tax-free reimbursements under the Plan than by claiming the tax credit. ***Consult your own tax advisor if you are in doubt as to whether to obtain reimbursements under the Plan or to take the tax credit.***

(k) *Qualified Dependent Care Expenses.* A dependent care expense is an amount paid by you for the care of a qualified dependent, including related household services, which enables you to be gainfully employed. The "qualified" dependent care expenses for which you are entitled to reimbursement under the DCAP are generally those dependent care expenses that are permitted under Section 129 of the Internal Revenue Code.

(i) *Qualified Dependent.* A qualified dependent is:

(A) Your child (as defined in Internal Revenue Code § 152) who is under age thirteen (13) and is your "qualifying child" as defined in Code § 152(a)(1); or

(B) Your tax dependent as defined in Code § 152, but determined without regard to Code § 152(b)(1), (b)(2), and (d)(1)(B), who:

(1) Is physically or mentally incapable of caring for himself/herself; and
(2) Is living with you for more than one-half of the calendar year.

(C) Your Spouse who is physically or mentally incapable of self-care and who is living with you for more than one-half of the calendar year.

If you are divorced or separated and have a child whom you do not claim as a dependent for federal income tax purposes, the child must be in your custody for at least six (6) months out of the year to be a qualified dependent.

(ii) *Types of Expenses Eligible For Reimbursement.* The following expenses are eligible for reimbursement:

(A) Payments for the care of a qualified dependent in your home. This includes care provided by a babysitter, nurse, or housekeeper in your home, as long as part of their service benefits the qualified dependent.

(B) Payments for the care of a qualified dependent outside your home. If such expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six (6) individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations. If such expenses are incurred for services performed outside your home for an individual described in (k)(i)(B) above, then such individual must be living with you at least eight (8) hours a day.

(C) Pre-school care, before- and after-school care, and day camp during school vacation.

(iii) *Types of Expenses Not Eligible For Reimbursement.* The following expenses are not eligible for reimbursement:

(A) Expenses paid through another policy or plan providing dependent care benefits to you or your Spouse.

(B) Amounts paid to your child who is age eighteen (18) or younger for babysitting or care of a qualified dependent.

(C) Expenses paid to a person whom you or your Spouse are entitled to claim as a dependent for federal income tax purposes.

(D) Expenses incurred prior to becoming a Participant in the DCAP.

(E) Education expenses for a child in kindergarten or any higher grade.

(F) Overnight care at a convalescent nursing home for a dependent Spouse or relative.

(G) Overnight camp.

(H) Expenses for lessons, tutoring, or certain types of transportation expenses.

(I) Forfeited deposits, but may include application fees, agency fees, and deposits if you are required to pay the expenses to obtain dependent care.

(l) *Run-Out Period.* "Run-Out Period" means the period that begins at the close of the Plan Year and ends on the September 30 immediately following the close of the Plan Year. Eligible expenses must be submitted for reimbursement before the end of the Run-Out Period.

(m) *Electronic Payment Card.* The Employer permits the use of an electronic payment card, such as a debit card, to pay for Qualified Dependent Care Expenses. The electronic payment card may only be used at service providers which are authorized by the Employer.

(n) *Claims Procedures.* In the event you have a claim for benefits under the DCAP, you should submit a claim using the claim form that will be provided to you by the Claims Administrator and follow the instructions on that form.

(i) *Claims Administrator.* The Employer has designated Surency to act as the Claims Administrator for the DCAP. As the Claims Administrator, Surency shall have the sole authority to grant or deny any claims for benefits under the Plan. If the Claims Administrator denies a claim, it will state its denial in writing and will deliver or mail to the Participant a notice of denial of benefits, setting forth the specific reasons for the denial. In addition, the Claims Administrator will give any Participant whose claim for benefits has been denied a reasonable opportunity for a review of the decision denying the claim.

(ii) *Electronic Payment Card.* If the Employer permits the use of an electronic payment card, such as a debit card, you may be able to access your DCAP through the use of such card, provided that the claim is properly adjudicated. If your funds are accessible by an electronic payment card, you must comply with the substantiation procedures in accordance with Rev. Rul. 2003-43 and other IRS guidance. Under those procedures, some payments with your electronic payment card may be automatically substantiated by this DCAP Plan; other payments may require further substantiation by you to the DCAP Plan.

(iii) *When to Submit a Claim.* You may submit your claim for reimbursement for expenses you incurred during the Plan Year in which incurred or within the Run-Out Period following the close of that Plan Year. If you terminate your participation in the DCAP, or if the Employer terminates the DCAP, you must submit your claim for reimbursement for that Plan Year no later than thirty (30) days after the date your participation in the Plan terminates or the date the Employer terminates the Plan, respectively. For example, if you terminate employment with the Employer on July 1 of a particular Plan Year, you must submit your claim for reimbursement no later than July 31 of that Plan Year to receive reimbursement for expenses covered by the plan which you incurred prior to that July 1.

(iv) *Claims Decisions and the Right to Appeal*. Within a reasonable time, not exceeding ninety (90) days (unless the Claims Administrator notifies you of an extension of up to ninety (90) days), the Claims Administrator will inform you of its decision to approve or deny your claim. If the Claims Administrator denies your claim, in whole or in part, you may have a right to appeal the decision.

(v) *Payment of Claims.* Approved claims will be paid directly to you. No claims will be paid to the provider of any services.

(vi) *Information Regarding Claims.* Prior to making any payment of benefits under the DCAP, the Claims Administrator may require you to provide such information and complete appropriate documents or forms necessary for the proper administration of the Plan. The Claims Administrator may rely upon all such information furnished to it, including your current mailing address.

(o) *Termination of Coverage.* Your participation in the DCAP ends on whichever of the following dates occurs first:

(i) The date that you terminate your employment with the Employer;

(ii) The date in which your election to participate expires;

(iii) The end of a period in which you last paid a required contribution; or

(iv) The date the Employer terminates the DCAP.

(9) Vision Plan

The Employer maintains a Vision Plan that pays benefits under a group contract with Surency Life & Health Insurance ("Surency"), P.O. Box 789773, Wichita, KS 67278-9773.

(a) *Type of Plan.* The Vision Plan is a group health plan. The Vision Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility/Plan Entry Dates.* The eligibility conditions and the Vision Plan entry dates are the same as those for the Plan.

(c) *Enrollment in the Plan.* **To become a Participant in the Vision Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Vision Plan entry date. **If you do not elect to participate in the Vision Plan, you will not receive any benefits under the Vision Plan.**

(i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you will not be allowed to enroll in the Vision Plan until the next open enrollment period and your enrollment will not take effect until the anniversary date of the Surency group contract. The same rule applies if you fail to enroll your dependents (including your Spouse) when you are first eligible to do so. This rule does not apply, however, if you are entitled to HIPAA "Special Enrollment" rights.

(d) *Plan Benefits.* If you elect to participate in the Vision Plan, benefits will be provided by the Employer pursuant to the terms and conditions of a group contract between the Employer and Surency. This Vision Plan provides you and/or your dependents with comprehensive vision coverage. Surency has prepared materials which explain the benefits under this Vision Plan in detail. If you have not received these materials from Surency, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.

(e) *Obligation to Pay Benefits.* Surency is solely obligated to pay for the benefits provided under the Surency group contract. The Employer makes no promise and will have no obligation to provide or pay for benefits under the group contract.

(f) *Premiums.* The monthly premiums for insurance coverage under the Vision Plan are determined by Surency and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Premiums may be paid on a pre-tax basis through the Plan.

(g) *Vision Treatment.* The Vision Plan does not provide vision treatment or give vision advice. **It is your responsibility, in consultation with the doctor of your choice, to get appropriate vision treatment**. The fact that some expense may not be eligible for reimbursement by the Vision Plan does not mean that you or your dependents should not have that treatment.

(h) *Claims Procedures.* In the event you have a claim for benefits under the Vision Plan, you should follow the procedures outlined in the materials prepared by Surency, as applicable. The Plan Administrator, upon your request, will assist you in making these claims. Surency has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the group contract.

(i) *Explanation of Benefits.* You will receive an explanation of benefits (EOB) under the Vision Plan at your primary residence (as provided to the Claims Administrator, i.e., the insurance company for fully insured plans or third-party administrator for self-funded plans). If your covered Spouse or dependent does not wish for an EOB to be provided at this address, he/she will need to contact the claims administrator and provide an alternate address.

(j) *Termination of Coverage.* Your participation in the Vision Plan ends on whichever of the following dates occurs first:

(i) The last effective date of coverage – as specified by the insurance group contract – following your termination of employment with the Employer;

(ii) The date on which your election to participate expires;

(iii) The end of a period for which a required contribution by you was last paid, taking into account any grace periods required by law;

(iv) The last effective date of coverage – as specified by the insurance group contract – following the date on which you cease to be an Eligible Employee; or

(v) The day the Employer terminates the Vision Plan.

Your coverage for benefits under the Vision Plan ends with the termination of your participation. However, you may, in some circumstances, be entitled to purchase COBRA continuation coverage. COBRA continuation coverage is discussed in a separate section of this SPD.

(10) Group Life Plan

The Employer maintains a Group Life Plan that pays benefits under an insurance contract with Lincoln Financial Group ("Lincoln"), 1300 S. Clinton Street, Fort Wayne, Indiana 46802.

(a) *Type of Plan.* The Group Life Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator. The Group Life Plan is an Employer-Paid Benefit under the Plan.

(b) *Eligibility/Plan Entry Date.* The eligibility conditions and the Group Life Plan entry date are the same as those for the Plan.

(c) *Enrollment in the Plan.* **To become a Participant in the Group Life Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Group Life Plan entry date.

(i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you may be required to pass medical underwriting before you may enroll in the Group Life Plan.

(d) *Plan Benefits.* You will be insured under a group contract issued by Lincoln. This group contract provides you with life insurance. Lincoln has prepared materials which explain the benefits of the group contract in detail. Lincoln will provide these materials to you. If you do not receive a copy of these materials, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.

(e) *Obligation to Pay Benefits.* Lincoln is solely obligated to pay for the benefits provided under the Lincoln group contract. The Employer makes no promise, and will have no obligation, to provide or pay for benefits under the group contract.

(f) *Premiums.* The monthly premiums for insurance coverage under the Group Life Plan are determined by Lincoln and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will pay one hundred percent (100%) of the monthly premium cost.

(g) *Claims Procedures.* In the event you have a claim for benefits under the Group Life Plan, you should follow the procedures outlined in the materials prepared by Lincoln, as applicable. The Plan Administrator, upon your request, will assist you in making these claims. Lincoln has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the group contract.

(h) *Termination of Coverage.* Your participation in the Group Life Plan ends on whichever of the following dates occurs first:

(i) The last effective date of coverage – as specified by the insurance group contract – following your termination of employment with the Employer;

(ii) The last effective date of coverage – as specified by the insurance group contract – following the date on which you cease to be an Eligible Employee; or

(iii) The day the Employer terminates the Group Life Plan.

Your coverage for benefits under the Group Life Plan ends with the termination of your participation. However, you may be eligible for a conversion contract offered by Lincoln. Please refer to the group contract for further details.

(11) Voluntary Life Plan

The Employer maintains a Voluntary Life Plan that pays benefits under an insurance contract with Lincoln Financial Group ("Lincoln"), 1300 S. Clinton Street, Fort Wayne, Indiana 46802.

(a) *Type of Plan.* The Voluntary Life Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility/Plan Entry Date.* The eligibility conditions and the Voluntary Life Plan entry date are the same as those for the Plan.

(c) *Enrollment in the Plan.* **To become a Participant in the Voluntary Life Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Voluntary Life Plan entry date. **If you do not elect to participate in the Voluntary Life Plan, you will not receive any benefits under the Voluntary Life Plan.**

(i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you may be required to pass medical underwriting before you may enroll in the Voluntary Life Plan.

(d) *Plan Benefits.* If you elect to participate in the Voluntary Life Plan, you will be insured under a group contract issued by Lincoln. This group contract provides you with life insurance. Lincoln has prepared materials which explain the benefits of the group contract in detail. Lincoln will provide these materials to you. If you do not receive a copy of these materials, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.

(e) *Obligation to Pay Benefits.* Lincoln is solely obligated to pay for the benefits provided under the Lincoln group contract. The Employer makes no promise, and will have no obligation, to provide or pay for benefits under the group contract.

(f) *Premiums.* The monthly premiums for insurance coverage under the Voluntary Life Plan are determined by Lincoln and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Premiums may be paid on an after-tax basis through the Plan.

(g) *Claims Procedures.* In the event you have a claim for benefits under the Voluntary Life Plan, you should follow the procedures outlined in the materials prepared by Lincoln, as applicable. The Plan Administrator, upon your request, will assist you in making these claims. Lincoln has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the group contract.

(h) *Termination of Coverage.* Your participation in the Voluntary Life Plan ends on whichever of the following dates occurs first:

(i) The last effective date of coverage – as specified by the insurance group contract – following your termination of employment with the Employer;

(ii) The date on which your election to participate expires;

(iii) The end of a period for which a required contribution by you was last paid, taking into account any grace periods required by law;

(iv) The last effective date of coverage – as specified by the insurance group contract – following the date on which you cease to be an Eligible Employee; or

(v) The day the Employer terminates the Voluntary Life Plan.

Your coverage for benefits under the Voluntary Life Plan ends with the termination of your participation. However, you may be eligible for a conversion contract offered by Lincoln. Please refer to the group contract for further details.

(12) Short Term Disability Plan

The Employer maintains a Short Term Disability Plan that pays benefits under an insurance contract with Lincoln Financial Group ("Lincoln"), 1300 S. Clinton Street, Fort Wayne, Indiana 46802.

(a) *Type of Plan.* The Short Term Disability Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility/Plan Entry Date.* The eligibility conditions and the Short Term Disability Plan entry date are the same as those for the Plan.

(c) *Enrollment in the Plan.* **To become a Participant in the Short Term Disability Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Short Term Disability Plan entry date. **If you do not elect to participate in the Short Term Disability Plan, you will not receive any benefits under the Short Term Disability Plan.**

(i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you may be required to pass medical underwriting before you may enroll in the Short Term Disability Plan.

(d) *Plan Benefits.* If you elect to participate in the Short Term Disability Plan, you will be insured under a group contract issued by Lincoln. This group contract provides you with short term disability insurance. Lincoln has prepared materials which explain the benefits of the group contract in detail. Lincoln will provide these materials to you. If you do not receive a copy of these materials, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.

(e) *Obligation to Pay Benefits.* Lincoln is solely obligated to pay for the benefits provided under the Lincoln group contract. The Employer makes no promise, and will have no obligation, to provide or pay for benefits under the group contract.

(f) *Premiums.* The monthly premiums for insurance coverage under the Short Term Disability Plan are determined by Lincoln and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Premiums may be paid on an after-tax basis through the Plan.

(g) *Claims Procedures.* In the event you have a claim for benefits under the Short Term Disability Plan, you should follow the procedures outlined in the materials prepared by Lincoln, as applicable. The Plan Administrator, upon your request, will assist you in making these claims. Lincoln has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the group contract.

(h) *Termination of Coverage.* Your participation in the Short Term Disability Plan ends on whichever of the following dates occurs first:

(i) The last effective date of coverage – as specified by the insurance group contract – following your termination of employment with the Employer;

(ii) The date on which your election to participate expires;

(iii) The end of a period for which a required contribution by you was last paid, taking into account any grace periods required by law;

(iv) The last effective date of coverage – as specified by the insurance group contract – following the date on which you cease to be an Eligible Employee; or

(v) The day the Employer terminates the Short Term Disability Plan.

Your coverage for benefits under the Short Term Disability Plan ends with the termination of your participation. However, you may be eligible for a conversion contract offered by Lincoln. Please refer to the group contract for further details.

(13) Allstate After-Tax Plan

The Employer maintains the Allstate After-Tax Plan that permits Participants to elect to receive benefits under an insurance contract issued by Allstate Insurance Company ("Allstate"), 1819 Electric Rd. S.W., Roanoke, VA 24018.

(a) *Type of Plan.* The Allstate After-Tax Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility/Plan Entry Date.* The eligibility conditions are the same as those for the Plan. The Allstate After-Tax Plan entry date is the April 1 following date of hire.

(c) *Enrollment in the Plan.* **To become a Participant in the Allstate After-Tax Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Allstate After-Tax Plan entry date. **If you do not elect to participate in the Allstate After-Tax Plan, you will not receive any benefits under the Allstate After-Tax Plan.**

(d) *Plan Benefits.* If you elect to participate in the Allstate After-Tax Plan, you will be able to select from the following policies, whether they be individual policies of insurance or group contracts, which are issued by Allstate:

(i) Accident Plan;

(ii) Critical Illness Plan; and/or

(iii) Cancer Plan.

You will be insured under individual policies or group contracts issued by Allstate. The contracts provide you (and/or your dependents, if family coverage or riders are available and chosen) with one or more of the above types of insurance. Allstate has prepared materials which explain the benefits of the contracts in detail. Allstate will provide these materials to you. If you do not receive a copy of these materials, you should request a copy from the Plan Administrator. These materials are an additional part of this Summary Plan Description.

(e) *Obligation to Pay Benefits.* Allstate is solely obligated to pay for the benefits provided under the Allstate individual policies of insurance or the group contracts of insurance, as applicable. The Employer makes no promise, and will have no obligation, to provide or pay for benefits under the policy.

(f) *Premiums.* The monthly premiums for insurance coverage under the Allstate After-Tax Plan are determined by Allstate and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. You are required to pay one hundred percent (100%) of the monthly premium cost on an after-tax basis.

(g) *Claims Procedures.* In the event you have a claim for benefits under the Allstate After-Tax Plan, you should follow the procedures outlined in the materials prepared by Allstate as applicable. The Plan Administrator, upon your request, will assist you in making these claims. Allstate has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the individual insurance policy or the group contract, as applicable.

(h) *Termination of Coverage.* Your participation in the Allstate After-Tax Plan ends on whichever of the following dates occurs first:

(i) The last effective date of coverage – as specified by the applicable insurance policy – following your termination of employment with the Employer;

(ii) The date on which your election to participate expires;

(iii) The end of a period for which a required contribution by you was last paid, taking into account any grace periods required by law;

(iv) The last effective date of coverage – as specified by the applicable insurance policy – following the date on which you cease to be an Eligible Employee; or

(v) The day the Employer terminates the Allstate After-Tax Plan.

Your coverage for benefits under the Allstate After-Tax Plan ends with the termination of your participation. However, if you are covered under an individual insurance policy, you may be able to remain covered under the individual insurance policy outside this Plan. Similarly, if you are covered under a group contract, you may be able to remain covered under an *individual* insurance policy outside this Plan. Please refer to the individual policies or the group contract, as applicable, for further details.

(14) COBRA Coverage for Group Health Plans

Special Note: This Section only applies if your Employer is required to offer COBRA continuation coverage. Generally, your Employer is required to offer COBRA continuation coverage unless the "small employer" exception to COBRA applies. This exception is based on the number of employees that your Employer employed during the previous calendar year. Generally, if such number is *less than twenty (20)*, then your Employer is *not* subject to COBRA and you should disregard this Section. **In the event, however, that your Employer has twenty (20) or more employees as determined under COBRA**, this Section will apply to an employee covered under a Group Health Plan sponsored by the Employer and to such employee's covered Spouse and/or covered dependents. **If COBRA applies, you should read this Section carefully.**

COBRA coverage is a temporary extension of coverage under Group Health Plans, under certain circumstances, when coverage would otherwise end. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Group Health Plans when group health coverage would otherwise be lost. **This section generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The group health components of the Plan in which you may be enrolled are the Medical Plan, the Dental Plan, the Vision Plan and the Health FSA. COBRA (and the description of COBRA coverage contained in this SPD) applies only to the Group Health Plan benefits offered under the Plan and not to any other benefits offered under the Plan. The Plan provides no greater COBRA rights than what COBRA requires and nothing in this SPD is intended to expand your rights beyond COBRA's requirements.

(a) *Qualified Beneficiary.* After a qualifying event (described below) occurs, and any required notice of that event is properly provided to the Plan Administrator, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and your dependent children may become qualified beneficiaries and may be entitled to elect COBRA if coverage under a Group Health Plan is lost because of the qualifying event. (Certain newborns, newly-adopted children, and alternate recipients under NMSN may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

(b) *Continuation Coverage.* Continuation coverage is the same coverage that the Group Health Plan gives 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 Group Health Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

(c) *Qualifying Events.* COBRA continuation coverage is a continuation of group health coverage when coverage would otherwise end because of an event known as a "qualifying event." Specific qualifying events with respect to each type of qualified beneficiary are as follows:

(i) *Employee.* If you are an employee, you will become a qualified beneficiary if you lose (or will lose) your group health coverage under the Plan because either one of the following qualifying events happens:

(A) Your hours of employment are reduced; or

(B) Your employment ends for any reason other than for gross misconduct.

(ii) *Spouse*. If you are the covered Spouse of an employee, you will become a qualified beneficiary if you lose your group health coverage under the Plan because any of the following qualifying events happens:

(A) Your Spouse dies;

(B) Your Spouse's hours of employment are reduced;

(C) Your Spouse's employment ends for any reason other than for gross misconduct;

(D) Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

(E) You become divorced or legally separated from your Spouse. If your Spouse (the employee) reduces or eliminates coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

(iii) *Dependents.* If you are the covered dependent child of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

(A) Your parent-employee dies;

(B) Your parent-employee's hours of employment are reduced;

(C) Your parent-employee's employment ends for any reason other than for gross misconduct;

(D) Your parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

(E) Your parents become divorced or legally separated; or

(F) You stop being eligible for coverage under the plan as a "dependent child."

In addition to the above qualifying events, filing a proceeding in bankruptcy under Title 11 of the United States Code can sometimes 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 retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's Spouse, surviving Spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

(d) *FMLA Leave.* If you take FMLA leave and do not return to work at the end of the leave, you (and your Spouse and dependent children, if any) will be entitled to elect COBRA if you, your Spouse, and dependent children, if any, (i) were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave), and (ii) will lose Plan coverage within eighteen (18) months because of your failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Group Health Plan during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours.

(e) *Special Rule for Health FSAs.* COBRA coverage under a Health FSA will be offered only to qualified beneficiaries who have underspent accounts. A qualified beneficiary has an underspent account if he/she has been reimbursed less money than he/she has contributed.

(i) *COBRA Coverage.* COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan Year, and COBRA coverage will terminate at the end of the Plan Year.

(ii) *Qualified Beneficiaries.* Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. Each beneficiary, however, has separate election rights, and each could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, you should contact the Plan Administrator for more information.

(f) *Notice Procedures*. When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify the Employer of any of these three qualifying events. **For all other qualifying events, you must notify the Plan Administrator in writing within sixty (60) days after the date on which the qualifying beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event and in accordance with the procedures outlined in Appendix A to this SPD.**

(i) *Forms.* The notice procedures outlined in Appendix A may require that specific forms be used by you in providing proper notice of certain qualifying events to the Plan. The Plan will not provide you with an Election form to begin or extend COBRA coverage if it does not receive proper notice from you regarding the qualifying events listed in Appendix A.

(ii) *Failure to Follow Procedures.* **If the procedures outlined in Appendix A are not followed or if notice is not provided in writing to the Plan Administrator during the 60-day notice period, any Spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage.**

(g) *Electing COBRA Coverage*. Once the Plan Administrator receives *timely* notice that a qualifying event has occurred, COBRA coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect continuation coverage. For example, the covered employee's Spouse may elect COBRA even if the employee does not. COBRA may be elected for one (1), several, or for all dependent children who are qualified beneficiaries. Covered employees and Spouses (if the Spouse of a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. For each qualified beneficiary who timely elects COBRA coverage, COBRA coverage will begin on the date that Plan coverage would otherwise have been lost.

(h) *60-Day Election Period.* A qualified beneficiary must elect coverage in writing within sixty (60) days of losing coverage under the Plan (or, if later, within sixty (60) days of being provided a COBRA election notice), using the Plan's Election form and following the procedures specified on the Election form. (A copy of the Plan's Election form may be obtained from the Plan Administrator.) The Election form must be mailed or hand delivered to the address indicated at the beginning of this SPD and as indicated on the Plan's Election form. If you mail your Election, it must be postmarked no later than the last day of the 60-day Election period. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including e-mail and faxed communications.

(i) *Failure to Return Election Form.* **If you or your covered Spouse or covered dependent children do not elect continuation coverage within the 60-day election period, you will lose your right to elect continuation coverage.**

(ii) *Rejection of COBRA Rights.* If a qualified beneficiary rejects COBRA before the due date, he/she may change his/her mind as long as a completed Election form is furnished before the due date.

(iii) *Elections Under More Than One Group Health Plan.* Qualified beneficiaries may be enrolled in one or more group health benefits under the Plan at the time of a qualifying event. If a qualified beneficiary is entitled to a COBRA election as the result of a qualifying event, he/she may elect COBRA under any or all of the group health benefits under the Plan, and in which he/she was covered on the day before the qualifying event.

(i) *Length of COBRA Coverage.* The COBRA coverage periods described below are *maximum* coverage periods for each type of qualified event. COBRA coverage can end before the end of the maximum coverage periods for several reasons outlined in Subsection (k) below.

(i) *Employee's Termination of Employment.* COBRA continuation coverage may last for up to eighteen (18) months for the former employee, the Spouse, and any dependents who are qualified beneficiaries. The 18-month period for the Spouse and/or dependent child may be extended if a qualified beneficiary is disabled or if there is a "second qualifying event" as described in Subsection (j) below.

(ii) *Employee's Reduction of Hours.* COBRA continuation coverage may last for up to eighteen (18) months for the employee, Spouse, and any dependents who are qualified beneficiaries. The 18-month period for the Spouse and/or dependent child may be extended if a qualified beneficiary is disabled or if there is a "second qualifying event" as described in Subsection (j) below.

(iii) *Death of Employee.* COBRA continuation coverage may last for up to thirty-six (36) months for the Spouse and any dependents who are qualified beneficiaries.

(iv) *Employee Entitlement to Medicare.* COBRA continuation coverage may last for up to thirty-six (36) months for the Spouse and any dependents who are qualified beneficiaries.

(v) *Divorce or Legal Separation.* COBRA continuation coverage may last for up to thirty-six (36) months for the Spouse and any dependents who are qualified beneficiaries.

(vi) *Loss of Dependent Status.* COBRA continuation coverage may last for up to thirty-six (36) months for the dependent who is a qualified beneficiary.

(vii) *Special Rule for Health FSAs.* Regardless of which of the above qualifying events occurs, COBRA coverage under the Health FSA may not be continued beyond the end of the Plan Year in which the qualifying event occurred.

(j) *Extension of Maximum Coverage Period (Not applicable to Health FSA).* If the qualifying event that resulted in your COBRA election was the employee's termination of employment or reduction in hours, the 18-month maximum period may be extended if a qualified beneficiary who has elected COBRA coverage becomes disabled, if a "second qualifying event" occurs, or if the employee became entitled to Medicare in the 18-month period preceding his/her termination of employment or reduction of hours. (These extension opportunities do not apply to a period of COBRA coverage resulting from a covered employee's death, divorce or legal separation, or a dependent child's loss of eligibility.)

(i) *Disability Extension.* If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the Employer in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional eleven (11) months of COBRA coverage, for a total maximum of twenty-nine (29) months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction in hours. The disability must have started at some time before the sixty-first (61st) day after the covered employee's termination of employment or reduction in hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally eighteen (18) months). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

(ii) *Extension Due to a Second Qualifying Event.* An extension of coverage will be available to Spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the eighteen (18) months (or, in the case of a disability, the twenty-nine (29) months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is thirty-six (36) months. Such second qualifying events include the death of a covered employee, divorce, or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan if the first qualifying event had not occurred.

(iii) *Medicare Extension for Spouse and Dependents.* If a qualifying event that is a termination of employment or reduction of hours occurs within eighteen (18) months after the covered employee becomes entitled to Medicare, then the maximum coverage period for the Spouse and dependent children will end three years from the date the employee became entitled to Medicare (but the covered employee's maximum coverage period will be eighteen (18) months).

These extensions in subparagraphs (i) through (iii) above are available only if you timely notify the Employer in writing of the Social Security Administration's determination of disability and the second qualifying event within the 60-day notice period and the entitlement to Medicare within thirty (30) days of entitlement in accordance with the Plan's notice procedures found in Appendix A.

(iv) *Special Rule for Health FSAs.* Regardless of which of the above qualifying events occurs, COBRA coverage under the Health FSA will not be extended and will only continue until the end of the Plan Year in which the initial qualifying event occurred.

(k) *Termination of COBRA Coverage before End of Maximum Period.* Continuation coverage will be terminated before the end of the maximum period if:

(i) Any required premium is not paid before the end of the grace period;

(ii) After electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan;

(iii) After electing COBRA coverage, a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both);

(iv) The employer ceases to provide any Group Health Plan for its employees;

(v) During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled; or

(vi) Coverage would have been terminated under the same circumstances for a Participant or beneficiary not receiving continuation coverage, for example, if a Participant or beneficiary engages in fraudulent activities against the Plan.

(l) *Cost of COBRA Coverage.* Each qualified beneficiary is required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed one hundred two percent (102%) (or, in the case of an extension of continuation coverage due to a disability, one hundred fifty percent (150%)) of the cost to the Group Health Plan (including both employer and employee contributions) for coverage of a similarly-situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

(m) *First Payment.* All COBRA premiums must be paid by check or money order. If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election form. However, you must make your first payment for COBRA coverage within forty-five (45) days after the date of your Election. (This is the date the Election notice is post-marked, if mailed, or the date your Election form is received by the individual at the address specified for delivery of the Election form, if hand-delivered.) Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to the address indicated on the Election notice. You will not be considered to have made any payment by mailing or hand delivering a check if your check is returned due to insufficient funds or otherwise. **If you do not make your first payment for continuation coverage within that forty-five (45) days, you will lose all continuation coverage rights under the Plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment.

EXAMPLE: You terminate employment on September 30 and lose coverage on September 30. You elect COBRA on November 15. Your initial payment equals the premiums for October and November and is due on or before December 30, which is the forty-fifth (45th) day after the date of your COBRA election. You are responsible for making sure that the amount of your first payment is correct. You may contact the Employer to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

(n) *Monthly Payments for COBRA Coverage.* After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month, for each qualified beneficiary, will be disclosed in the Election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage.

EXAMPLE: You terminate employment on September 30 and lose coverage on September 30. You elect COBRA on October 15. Your initial payment is due on or before November 29 and should equal the premium for October. You will be required to make monthly premiums, starting with the month of November, by the first of each month. This means that the premium for November is due by the first of November.

(o) *Grace Periods*. Although periodic payments are due on the first day of each month of COBRA coverage, you will be given a grace period of thirty (30) days to make each monthly payment. Your COBRA coverage will be provided for each coverage period so long as payment for that coverage period is made before the end of the grace period for that payment. If you pay a monthly payment later than its due date but during its grace period, your coverage under the Plan may be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that payment/month, you will lose all rights to COBRA coverage under the Plan.

(p) *Children Born to or Placed for Adoption.* A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself/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 employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

(q) *Alternate Recipients Under NMSNs.* A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified National Medical Support Notice ("NMSN") received by the Employer during the covered employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

(r) *Address Changes.* In order to protect your family's rights, you should keep the Employer informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Employer.

(s) *Questions.* Questions concerning your Plan or your COBRA rights should be addressed to the Plan Administrator.

(15) USERRA Continuation Rights

If you are absent from employment as a result of military service, you will have the right to elect continuation coverage for a period of up to twenty-four (24) months if such coverage would otherwise be lost as a result of such military service. Your right to continue coverage is subject to the following:

(a) *Payment of Premium.* You must pay the applicable premium for any USERRA continuation coverage. For a leave of absence for less than thirty-one (31) days, you may not be required to pay more than you would have paid had you not been on leave. For a leave of absence of more than thirty (30) days, you must pay the entire cost of coverage plus an additional two percent (2%).

(b) *Failure to Apply for Reemployment.* Following completion of your military service, your right to continue coverage under USERRA will end if you do not apply for reemployment within the applicable time period set forth in USERRA (43 U.S.C. § 4312(c)).

(16) Group Health Plan Claims Procedures (Not applicable to the Health FSA)

Payment by the Claims Administrator is based on data furnished by you. In order to collect benefits under the Plan, you must first provide the Claims Administrator with information about your claim for benefits.

Claims made for benefits under the fully-insured Group Health Plans, and any appeals from the denial of such Claims, shall be processed in accordance with the claims procedures of the insurer. Unless otherwise stated in your applicable insurance policy, before filing any legal action against the Plan, the Employer, the Plan Administrator, or the Claims Administrator, you must first exhaust the administrative remedies summarized in your policy. This means, for example, that, if a claim is denied, you must appeal the denial following the procedures provided in your policy of insurance. If you do not exhaust your administrative remedies, you will not be allowed to file a civil action concerning a claim for benefits under the Plan. Unless otherwise stated in your applicable insurance policy, following the Plan's issuance of a final adverse benefit determination, you will have one hundred eighty (180) days to file a legal action against the Plan, the Employer, the Plan Administrator, or the Claims Administrator. Failure to meet this deadline will result in the forfeiture of any Claim that you may have.

(17) Miscellaneous

(a) *National Medical Support Notice.* Participants in a Group Health Plan and their beneficiaries may obtain from the Plan Administrator, without charge, a copy of the plan's procedures governing the determination of whether an order is a "national medical support notice" ("NMSN").

(b) *Family and Medical Leave Act.* If you take an unpaid leave under the FMLA, the Employer will, to the extent required by the FMLA, continue to maintain your benefits under a Group Health Plan on the same terms and conditions as though you were still an active Employee.

If you choose to continue your coverage while you are on a FMLA leave, the Employer will continue to pay its share (if any) of the premiums. You will be required, if you choose to continue your coverage, to pay your share of the premiums in one or more of the following ways:

(i) You may pay your share of the premiums with after-tax dollars while you are on FMLA leave (or with pre-tax dollars to the extent you receive Compensation from the Employer during your leave).

(ii) You may pay your share of the premium pursuant to such other arrangement as may be agreed upon between you and the Plan Administrator.

If your coverage ceases while you are on FMLA leave, you will be permitted to reenter the Plan immediately upon your return from FMLA leave on the same basis that you were participating in the Plan prior to your leave, or as otherwise required by the FMLA.

(c) *Return of Premium.* If money is returned in any form by an insurance company that provided or is providing benefits under the Plan, including, but not limited to, a rebate of premiums previously paid, proceeds from demutualization, or rebates resulting from an insufficient "medical loss ratio" (MLR), the Plan Administrator shall have the discretion to apply such amounts to the payment of Plan expenses, the reduction of premiums, and/or benefit enhancements. The Plan Administrator shall further have the discretion to allocate such funds in any manner deemed appropriate.

(d) *Returns of Benefit Payments Made in Error.* The Plan shall have the right to reimbursement from you, your covered dependents, or assignees for any benefit overpayments attributable to mistake, clerical error, fraud, or any other reason contributing to benefit payments to which you, your covered dependents, or assignees were not entitled.

(18) Notice of Hospital Rights for Newborns and Mothers

HIPAA requires this SPD to include the following explanation of your rights under the Health Insurance Portability and Accountability Act of 1996. Please note that this statement is made to you by the federal government. Therefore, the Employer and the Plan Administrator are not responsible for the accuracy or completeness of the explanation, and some of the provisions may not apply to the Plan.

Group health plans and health insurance issuers 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 caesarean 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).

(19) Notice of Rights under the Women's Health and Cancer Rights Act of 1998

The Employer is required by federal law to provide the following notice:

If a group medical plan provides medical and surgical benefits for mastectomies, that plan must also provide coverage for the following, if they are agreed upon by a participant or beneficiary who is receiving benefits in connection with a mastectomy and that person's attending physician:

(a) Reconstruction of the breast on which the mastectomy has been performed;

(b) Reconstruction of the other breast to produce a symmetrical appearance; and

(c) Prostheses and physical complications of mastectomies, including lymph edemas.

This coverage must be the same as for any other benefit under the plan and is subject to the plan's annual deductibles and co-payment requirements.

(20) Notice of Opportunity to Enroll Adult Children up to Age 26

Effective April 1, 2011, under the Patient Protection and Affordable Care Act of 2010, your children generally can be covered under the Medical Plan until they attain age twenty-six (26), regardless of their student or marital status and regardless of whether your home is their principal place of abode or whether you support them. Thus, children whose coverage under the Medical Plan ended, who were denied coverage, or who were not eligible for coverage because the availability of dependent coverage of children under the Plan ended before attainment of age twenty-six (26), may be eligible for coverage under the Plan beginning April 1, 2011.

(21) No Lifetime Limit under the Medical Plan

Effective April 1, 2011, the lifetime limit on the dollar value of benefits under the Medical Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the Medical Plan are eligible to enroll in the Medical Plan. For more information, contact the Plan Administrator at the address provided at the beginning of this SPD.

(22) Patient Protection Notice

To the extent that the Medical Plan requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in the Medical Plan's network of providers and who is available to accept you or your family members. If the Medical Plan requires the designation of a primary care provider and you do not designate one yourself, the Medical Plan will designate one for you until you make the designation yourself. In addition, if you have children covered under the Medical Plan, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator at the address at the beginning of this SPD or the insurance carrier referred to in the Medical Plan section of this SPD.

Finally, please note that you do not need prior authorization from the Medical Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or adhering to certain procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator at the address at the beginning of this SPD or the insurance carrier referred to in the Medical Plan section of this SPD.

(23) Right of Employer to Amend or Terminate

The Employer may at any time amend or terminate the Plan, including any of the plans that are summarized in this SPD, by a written instrument signed by the Superintendent of the Employer, as provided for in each of the respective plan documents. Any amendment to any plan will be added to the Plan in writing and communicated to Participants.

* * * * * * * * * * * * * * *

APPENDIX A
COBRA NOTICE PROCEDURES

As an individual covered by the Plan, your right to begin COBRA coverage or to extend or maintain current COBRA coverage is affected by the events listed in the first column of the table below. If you wish to qualify for COBRA continuation coverage, you must provide the Plan with notice of the occurrence of any one of these events in accordance with the procedures outlined in this table. Any required forms may be obtained from the Plan Administrator. Once completed, the various kinds of notices described below must be mailed or hand-delivered to the following address:

Discovery Benefits
4321 20th Avenue SW
Fargo, ND 58103

Notice must be in writing. Oral notice, including notice by telephone is not acceptable. Electronic (including e-mailed or faxed) notices are also not acceptable. If mailed, notice must be postmarked no later than the deadline date. If hand-delivered, your notice must be received by the individual at the address specified above no later than the deadline date.

If COBRA coverage should have been terminated but was not, due to a lack of notice from a qualified beneficiary, the Employer will immediately terminate coverage and require payment to the Plan of all benefits paid after what should have been the termination date.

The following terms have been abbreviated: QE = Qualifying Event QB = Qualified Beneficiary SSA = Social Security Administration

NOTICE OF:	DEADLINE FOR PROVIDING NOTICE	REQUIRED INFORMATION IN THE NOTICE	INCOMPLETE NOTICES[1]	WHO MAY PROVIDE NOTICE
DIVORCE OR LEGAL SEPARATION[2]	Notice must be provided 60 days after the date on which covered spouse would lose coverage under the terms of the Plan as a result of the divorce or legal separation.	Your notice must contain the following: (1) Name of the Plan; (2) Name/address of employee or former employee who is/was covered; (3) Name/address of all QBs who lost coverage due to the QE; (4) The QE; (5) A copy of the divorce or legal separation decree; (6) Date of the QE; and (7) Signature, name and contact information of individual sending the notice.	If you provide a notice that does not contain all of the information and documentation required by these notice procedures, such a notice will nevertheless be considered timely if all of the following conditions are met:[3] (1) Notice is mailed/hand-delivered to the address specified at the beginning of this Appendix; (2) Notice deadline is met; (3) From the written notice provided, the Employer can tell that the notice relates to the Plan; and (4) From the written notice provided, the Employer is able to identify the covered employee and QB(s), the QE, and the date on which it occurred.	(1) Covered Employee; (2) Formerly Covered Employee; (3) A QB with respect to the QE; or (4) Representative acting on behalf of the covered (or formerly covered) employee or the QB. A notice provided by any of the above listed individuals will satisfy any responsibility to provide notice on behalf of all QBs who lost coverage due to the QE described in the notice.

[1] In addition to the conditions listed in this column, for each qualifying event, the notice must also be supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements within 15 business days after a written or oral request from Employer for more information.

[2] *Anticipation of Divorce or Legal Separation.* If your coverage is reduced or eliminated and a divorce or legal separation later occurs, you may be able to receive COBRA coverage if you can show that your coverage was reduced or eliminated in anticipation of the divorce or legal separation. You must notify the Employer of this within 60 days of the divorce or legal separation in accordance with these procedures. You must also provide evidence satisfactory to the Employer that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

[3] If any one of the conditions is not met, the incomplete notice will be rejected and COBRA will not be offered. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

QE = Qualifying Event QB = Qualified Beneficiary SSA = Social Security Administration

NOTICE OF:	DEADLINE FOR PROVIDING NOTICE	REQUIRED INFORMATION IN THE NOTICE	INCOMPLETE NOTICES[1]	WHO MAY PROVIDE NOTICE
LOSS OF DEPENDENT STATUS UNDER THE PLAN	Notice must be provided 60 days after the date on which the covered dependent child would lose coverage under the terms of the Plan due to the loss of dependent status.	Your notice must contain the following: (1) Name of the Plan; (2) Name/address of employee or former employee who is/was covered; (3) Name/address of all QBs who lost coverage due to QE; (4) Statement of the QE; (5) Date of the QE; (6) If requested, documentation satisfactory to Employer of the date of the QE (e.g., a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution);[4] and (7) Signature, name and contact information of individual sending the notice.	Same as above.	Same as above.
DISABILITY	Notice must be provided 60 days after the latest of (1) the date of the SSA's disability determination; and (2) the date on which the QB would lose coverage under the terms of the Plan as a result of the termination of employment or reduction in hours. Your notice must also be provided within 18 months after the QEs of termination of employment and reduction of hours.	Your notice must contain the following: (1) Name of the Plan; (2) Name/address of employee or former employee who is/was covered under the Plan; (3) The initial QE that started COBRA coverage (i.e., termination of employment or reduction in hours); (4) Name/address of all QBs who lost coverage due to the initial QE and who are receiving COBRA coverage at the time of the notice; (5) Name/address of disabled QB; (6) Date of the QE; (7) Date SSA made its determination of disability; (8) Statement as to whether or not SSA has subsequently determined that QB is no longer disabled; and (9) Signature, name and contact information of individual sending the notice. Notice must include a copy of SSA's determination of disability.	If you provide a notice that does not contain all of the information and documentation required by these notice procedures, such a notice will nevertheless be considered timely if all of the following conditions are met:[5] (1) Notice is mailed/hand-delivered to address specified at the beginning of this Appendix; (2) Notice deadline is met; (3) From the written notice provided, Employer can tell that the notice relates to the Plan and the QB's disability; and (4) From the written notice provided, Employer is able to identify the covered employee, the QB(s), the QE, and the date on which the covered employee's termination of employment or reduction in hours occurred.	Same as above. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all QBs who may be entitled to an extension of the maximum COBRA coverage period due to the disability reported in the notice.

[4] This will allow the Employer to determine that you gave timely notice of the QE and were consequently entitled to elect COBRA. If you do not provide satisfactory evidence within 15 business days after a written or oral request from Employer that the child ceased to be a dependent on the date specified in your notice of QE, his or her COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage would have started.

[5] If any one of the above conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

QE = Qualifying Event QB = Qualified Beneficiary SSA = Social Security Administration

NOTICE OF:	DEADLINE FOR PROVIDING NOTICE	REQUIRED INFORMATION IN THE NOTICE	INCOMPLETE NOTICES[1]	WHO MAY PROVIDE NOTICE
SECOND QUALIFYING EVENT – DIVORCE OR LEGAL SEPARATION	Notice must be provided 60 days after the date on which covered spouse would lose coverage under the terms of the Plan as a result of the divorce or legal separation if it had occurred while the QB was still actively covered under the Plan.	Your notice must contain the following: (1) Name of the Plan; (2) Name/address of employee or former employee who is/was covered; (3) The initial QE that started your COBRA coverage (i.e., termination of employment or reduction of hours); (4) Name/address of all QBs who lost coverage due to above stated QE and who are receiving COBRA at the time of the notice; (5) The second QE (i.e., divorce or legal separation); (6) Date of the second QE; (7) A copy of the decree of divorce or legal separation; and (8) Signature, name and contact information of individual sending the notice.	If you provide a notice that does not contain all of the information and documentation required by these notice procedures, such a notice will nevertheless be considered timely if all of the following conditions are met:[6] (1) Notice is mailed/hand-delivered to address specified at the beginning of this Appendix; (2) Notice deadline is met; (3) From the written notice provided, the Employer can tell that the notice relates to the Plan; and (4) From the written notice provided, the Employer is able to identify the covered employee and QB(s), the first QE, the date on which the first QE occurred, the second QE, and the date on which the second QE occurred.	(1) Covered Employee (2) Formerly Covered Employee (3) A QB who lost coverage due to the covered employee's termination or reduction of hours and who is still receiving COBRA coverage (4) Representative acting on behalf of the covered (or formerly covered) employee or the QB A notice provided by any of the above listed individuals will satisfy any responsibility to provide notice on behalf of all QBs who lost coverage due to the QE described in the notice.
SECOND QUALIFYING EVENT – LOSS OF DEPENDENT STATUS	Notice must be provided 60 days after the date on which covered dependent child would lose coverage under the terms of the Plan as a result of the second QE if the event had occurred while the QB was still actively covered under the Plan.	Your notice must contain the following: (1) Name of the Plan; (2) Name/address of employee or former employee who is/was covered; (3) The initial QE that started your COBRA coverage (i.e., termination of employment or reduction of hours); (4) Name/address of all QBs who lost coverage due to above stated QE and who are receiving COBRA at the time of the notice; (5) The second QE; (6) Date of the second QE; (7) If requested, documentation that is satisfactory to Employer (e.g., a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution) of the date of the QE;[7] and (8) Signature, name and contact information of individual sending the notice.	If you provide a notice that does not contain all of the information and documentation required by these notice procedures, such a notice will nevertheless be considered timely if all of the following conditions are met:[8] (1) Notice is mailed/hand-delivered to address specified at the beginning of this Appendix; (2) Notice deadline is met; (3) From the written notice provided, the Employer can tell that the notice relates to the Plan; and (4) From the written notice provided, the Employer is able to identify the covered employee and QB(s), the first QE, the date on which the first QE occurred, the second QE, and the date on which the second QE occurred.	Same as divorce (or legal separation) when it is a *second* QE.

[6] If any one of the above conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

[7] This will allow the Employer to determine that you gave timely notice of the second QE and were consequently entitled to an extension of COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written or oral request from Employer that the child ceased to be a dependent on the date specified in your notice, his or her COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage *would* have ended without an extension due to loss of dependent status.

[8] If any one of the above conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

QE = Qualifying Event QB = Qualified Beneficiary SSA = Social Security Administration

NOTICE OF:	DEADLINE FOR PROVIDING NOTICE	REQUIRED INFORMATION IN THE NOTICE	INCOMPLETE NOTICES[1]	WHO MAY PROVIDE NOTICE
SECOND QUALIFYING EVENT **-** **DEATH OF EMPLOYEE OR FORMERLY COVERED EMPLOYEE**	Notice must be provided 60 days after the date on which covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the death of the covered employee or formerly covered employee if the death had occurred while the QB was still actively covered under the Plan.	Your notice must contain the following: (1) Name of the Plan; (2) Name/address of employee or former employee who is/was covered; (3) The initial QE that started your COBRA coverage (i.e., termination of employment or reduction of hours); (4) Name/address of all QBs who lost coverage due to above stated QE and who are receiving COBRA at the time of the notice; (5) The second QE; (6) Date of the second QE; (7) If requested, documentation of the date of the death that is satisfactory to Employer (e.g., a death certificate or published obituary);[9] and (8) Signature, name and contact information of individual sending the notice.	If you provide a notice that does not contain all of the information and documentation required by these notice procedures, such a notice will nevertheless be considered timely if all of the following conditions are met:[10] (1) Notice is mailed/hand-delivered to address specified at the beginning of this Appendix; (2) Notice deadline is met; (3) From the written notice provided, the Employer can tell that the notice relates to the Plan; and (4) From the written notice provided, the Employer is able to identify the covered employee and QB(s), the first QE, the date on which the first QE occurred, the second QE, and the date on which the second QE occurred.	Same as divorce (or legal separation) when it is a *second* QE.
OTHER COVERAGE	Notice that a QB has become covered after electing COBRA under other group health plan, coverage must be provided 30 days after the other coverage becomes effective.	Your notice must contain the following: (1) Name of the Plan; (2) Name/address of employee or former employee who is/was covered; (3) Name/address of all QBs, specifying the one who obtained other coverage; (4) The QE that started your COBRA coverage; (5) Date of the QE; (6) The date the other coverage became effective;* (7) Evidence of the effective date of the other coverage (e.g., copy of insurance card or application for coverage); and (8) Signature, name and contact information of individual sending the notice.	If a QB first becomes covered by other group health plan coverage after electing COBRA, that QB's COBRA coverage will terminate (retroactively if applicable) as described in the COBRA Continuation Coverage section of the SPD.	Same as divorce (or legal separation) when it is an initial QE.

[9] This will allow the Employer to determine that you gave timely notice of the second QE and were consequently entitled to an extension of COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written or oral request from Employer that the death was the date specified in your notice of QE, the COBRA coverage of all QBs receiving an extension of COBRA as a result of the covered employee's death may be terminated (retroactively if applicable) as of the date that COBRA coverage would have ended without an extension due to the covered employee's death.

[10] If any one of the above conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

QE = Qualifying Event QB = Qualified Beneficiary SSA = Social Security Administration

NOTICE OF:	DEADLINE FOR PROVIDING NOTICE	REQUIRED INFORMATION IN THE NOTICE	INCOMPLETE NOTICES[1]	WHO MAY PROVIDE NOTICE
MEDICARE ENTITLEMENT	Notice that a QB has become entitled, after electing COBRA, to Medicare Part A, Part B or both, must be provided 30 days after the beginning of Medicare entitlement (as shown on the Medicare card).	Your notice must contain the following: (1) Name of the Plan; (2) Name/address of employee or former employee who is/was covered; (3) Name/address of all QBs, specifying the one who became entitled to Medicare; (4) The QE that started your COBRA coverage; (5) Date of that QE and the date that Medicare entitlement occurred; (6) A copy of the Medicare card showing the date of Medicare entitlement; and (7) Signature, name and contact information of individual sending the notice.	If a QB first becomes entitled to Medicare Part A, Part B, or both after electing COBRA, that QB's COBRA coverage will terminate (retroactively if applicable) as described in the COBRA Continuation Coverage section of the SPD.	Same as divorce (or legal separation) when it is an initial QE.
CESSATION OF DISABILITY	Notice that a disabled QB whose disability resulted in an extended COBRA coverage period is no longer disabled (as determined by the SSA) must be provided 30 days after the other coverage becomes effective or, if later, 30 days after the date of the SSA's determination.	Your notice must contain the following: (1) Name of the Plan; (2) Name/address of employee or former employee who is/was covered; (3) Name/address of all QBs, specifying who was the disabled QB; (4) State the QE that started your COBRA coverage; (5) Date of the QE; (6) Date of the SSA's determination that QB is no longer disabled; (7) A copy of SSA determination; and (8) Signature, name and contact information of individual sending the notice.	If a disabled QB is determined by SSA to be no longer disabled, COBRA coverage for all QBs whose COBRA coverage is extended due to the disability will terminate (retroactively if applicable) as described in the COBRA Continuation Coverage section of the SPD.	Same as divorce (or legal separation) when it is an initial QE.

MINUTES AND RESOLUTIONS

LANGUAGE FOR USD #262 VALLEY CENTER MINUTES

WHEREAS, the Superintendent of USD #262 Valley Center has recommended that the **USD #262 Valley Center Welfare Benefit Plan** be amended and restated; and

WHEREAS, the Board of Education members deem it to be in the best interests of USD #262 Valley Center to further approve the same.

NOW THEREFORE, BE IT RESOLVED, that the Superintendent be, and hereby is, authorized and directed to execute and deliver the **USD #262 Valley Center Welfare Benefit Plan** as amended and restated.

BENEFIT ELECTION/SALARY REDUCTION AGREEMENTS

Surency AdvantagePlus
USD #262 Valley Center Welfare Benefit Plan
PRE-TAX EMPLOYEE
BENEFIT ELECTION AND SALARY REDUCTION AGREEMENT

Instructions

1. Complete this form in order to elect to receive benefits pre-tax and/or open an FSA. (* = Required Fields)
2. Fax completed form to 316.462.3394 OR forward to:
   Surency Life & Health
   PO Box 789773
   Wichita, KS 67278-9773
   www.surency.com
3. If you have any questions regarding this form, please call 866.818.8805.

Accountholder Profile Information

* Last Name, First Name, MI (Please Print)	* Employer	* Social Security Number or Employee ID (EID) as appropriate
* Street Address	* City, State, Zip	* Date of Birth (mm/dd/yyyy)
* E-mail Address	* Daytime Phone Number	* Home Phone Number

* Gender ☐ Male ☐ Female

* Marital Status ☐ Married ☐ Single

*Payroll Frequency	☐ Monthly	☐ Bi-Weekly (24)	☐ Weekly
	☐ Semi-Monthly	☐ Bi-Weekly (26)	☐ Other

* Hire Date (mm/dd/yyyy)

*Hours Worked Per Week

***Pre-Tax Benefits Election** (Please choose one of the following enrollment options)

☐ I want to receive the pre-tax benefits available through the USD #262 Valley Center Welfare Benefit Plan ("Plan"). By signing below, I authorize USD #262 Valley Center ("Company") to reduce my salary by the amount necessary to pay my share of the cost for the following benefits in which I have enrolled myself and/or my beneficiaries.

(Please complete the section immediately below)

Medical Premiums		Dental Premiums		Vision Premiums	

☐ I understand the benefits offered under the pre-tax benefit election, however, I decline to participate in the above benefits offered under the Plan for this plan year. I understand that, as a result of this decision, I will not receive any of the pre-tax benefits available through the Plan.

(Please sign below and return)

Note: You may be required to complete a separate enrollment form to participate in the above benefits. This pre-tax election form does not entitle you to coverage under these benefits. It only entitles you to receive these benefits on a pre-tax basis if you choose to enroll in coverage under these benefits.

***FSA Election** (Please choose one of the following enrollment options)

☐ I am enrolling in an FSA through my employer. By signing below, I authorize the Company to reduce my salary by the amount necessary to pay my share of the cost for the following benefits in which I have enrolled myself and/or my beneficiaries. ***(Please complete the section immediately below)***

☐ I understand the benefits offered under the pre-tax spending program (FSA), however, I choose not to enroll in the program for this plan year. I understand that, as a result of this decision, I will not receive any of the pre-tax benefits available through the FSA Plan for this plan year. ***(Please sign below and return)***

Note: Your employer may also make a contribution to your FSA that will apply to your maximum contribution allowed. You are solely responsible for determining whether contributions to an FSA exceed the maximum annual contribution limitation.

Plan Type	Amount per pay period		# of Payroll Deductions		Annual Election
Medical FSA					
Limited FSA		x		=	
Dependent Care FSA		x		=	

Plan Type	Amount per pay period		# of Payroll Deductions		Annual Election
Transit FSA		x		=	
Parking FSA		x		=	

Check with your employer as to the availability of the Surency AdvantagePlus products listed

If there is a discrepancy between the "per pay period" amount and the "annual election" amount, the "per pay period" amount will be used to enter election amounts

***Surency AdvantagePlus Benefits Card** *Check with your employer as to the availability of the Surency AdvantagePlus Benefits Card*

Would you like to access your FSA funds using the Benefits Card? ☐ Yes ☐ No

By checking 'Yes', I certify that the benefits card will only be used for eligible medical expenses, as defined in Code §213(d) of the Internal Revenue Code and that I will not seek reimbursement from any other source for the expenses paid for with the benefits card.

Note: To issue separate debit cards to any dependents eighteen (18) years of age or older, please complete and submit the Additional Benefit Card Request Form.

Reimbursement Method -** ***Choose only one method
Please select your primary method of reimbursement from your FSA.

☐ Direct Deposit – You will need to provide your bank account information in the Direct Deposit Setup section.

☐ Check – All reimbursements will be paid by sending you a check. If choosing this option, skip the Direct Deposit Setup section.

Note: Surency will not issue a reimbursement check until the sum of your claims reaches $25.

Direct Deposit Setup
This section is required if you have chosen Direct Deposit as your FSA Reimbursement Method above.

*Bank Name

*Account Type ☐ Checking ☐ Savings

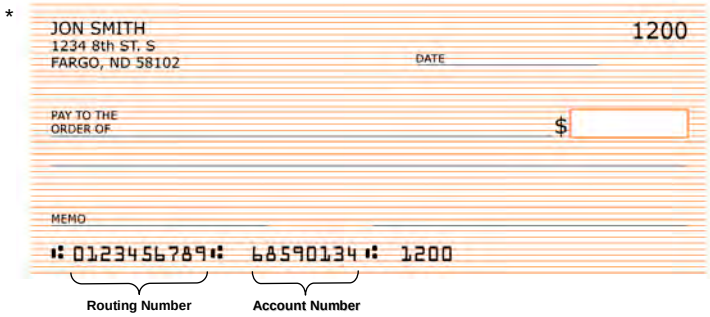
*Bank Address

*City, State, Zip

*Routing Number

*Account Number

Attach
Voided Check



Important Information

(1) By signing below, you are making a binding election concerning your benefits. You may not change your election until the next enrollment period unless you experience a qualifying "election change event" as defined in the provisions of the Plan.

(2) A special rule applies to the dollar amounts elected for the Health FSA. If you experience a qualifying "election change event" after the beginning of a plan year, you may begin, increase, decrease or cease your participation in the Health FSA. You may not, however, *decrease* the dollar amount of your election below the total of the amount you have already been reimbursed through the date of the election change event.

(3) Your election will not remain in effect for subsequent plan years. You must complete a Benefit Election and Salary Reduction Agreement for each plan year. The dollar amounts elected for the Health FSA and Dependent Care Account will automatically be reset to zero for subsequent plan years unless you make a new election for a subsequent plan year.

(4) The dollar amounts, if any, remaining in your Dependent Care Account at the end of the Plan Year will be forfeited, as required by IRS regulations, if your eligible expenses are not properly submitted for reimbursement before the end of the Run-Out Period. However, if any dollar amount, not exceeding $500, remains in your Health FSA Account at the end of the Plan Year, the amount may be "carried over" to the subsequent Plan Year. The "carryover amount" is determined on the last day of the Run-Out Period for that Plan Year. (The Run-Out Period is 30 days, measured from the last day of the Plan Year.) Any amount remaining in excess of the carryover amount shall be forfeited. This is commonly referred to as a "use it or lose it" rule.

(5) By choosing to receive the benefits available through the Plan, you are authorizing the Company to reduce your salary by the amount necessary to pay your share of the cost for those benefits. By doing this you will reduce your taxable compensation. As a result, depending on your compensation level, you may pay less Social Security tax and this may have some effect on the amount of your Social Security retirement benefits.

The above information is a summary of the provisions of the Plan. In the event of a conflict between this summary and the provisions of the Plan, the provisions of the Plan will control.

By signing below, you agree that the Company can deduct from your wages, to the extent permitted by applicable state law, the amount of any reimbursement paid to you under the Company's Health FSA or Dependent Care Account that is later determined to have been made without proper substantiation or otherwise improperly reimbursed.

I have read and understand the above information and I acknowledge that I have received the Summary Plan Description for the Plan. I have chosen the Benefit Election(s) marked on this form.

_____
*Employee Effective Date (mm/dd/yyyy)
Complete only if different than plan year effective date.

_____ _____
*Employer Signature *Date (mm/dd/yyyy)

_____ _____
*Employee Signature *Date (mm/dd/yyyy)

USD #262 VALLEY CENTER WELFARE BENEFIT PLAN
AFTER-TAX EMPLOYEE
BENEFIT ELECTION AND SALARY REDUCTION AGREEMENT

Employee Name:_____ Social Security Number:_____

Benefit Election – Select One of the Options Below

By signing below, I authorize USD #262 Valley Center, to deduct from my compensation, on an **after-tax** basis, the amount necessary to pay my share of the cost for the following benefit(s) in which I have enrolled myself and/or my beneficiaries:

☐ Short Term Disability Plan

☐ Voluntary Life Plan

☐ Accident Plan

☐ Critical Illness Plan

☐ Cancer Plan

(Check the coverage(s) in which you have enrolled yourself and/or your beneficiaries)

Important Information

Your election will not remain in effect for subsequent plan years. You must complete a new salary reduction form for each plan year. Information about each Plan is found in the Summary Plan Description for that Plan. Copies of the Plan documents are available upon request from the Plan Administrator.

I have read and understand the above information and I acknowledge that I have received the Summary Plan Description for the Plan. I have chosen the Benefit Election(s) marked on this form.

_____ _____

Signature Date

USD #262 VALLEY CENTER WELFARE BENEFIT PLAN
REQUEST TO CHANGE PRE-TAX ELECTIONS

Employee Name: _____ **Social Security Number:** _____

INSTRUCTIONS. *Please read the following instructions carefully.*

In order to change your election(s) under the USD #262 Valley Center Welfare Benefit Plan, you must do the following:

(1) Fill out and return a new Benefit Election and Salary Reduction Agreement
(2) Tell us why you would like to make a new election or change your current election(s) (using this form)
(3) Tell us when the event that may allow you to change your election took place (or will take place) (using this form)

After you have provided us with the above information, we will review your request. In determining whether we should accept or deny your request, we must follow IRS rules and the rules set forth in the USD #262 Valley Center Welfare Benefit Plan. This means, among other requirements, that your request to change your election(s) must be consistent with and on account of the "event(s)" that you have marked below. ***In addition, you must submit your request within 30 days from the date of the event(s) (or 60 days if the election change event is a HIPAA special enrollment right related to eligibility for a State premium assistance subsidy or related to a loss of eligibility for Medicaid or SCHIP).***

If your request to change your election(s) is approved, it will become effective as follows:

(1) HIPAA Special Enrollment for New Dependent. If your request relates to enrolling a dependent that you have acquired by birth or adoption in the USD #262 Valley Center Medical Plan, your request will take effect on the date of birth or adoption, even if you submit your request *after* the event (provided you do so within 30 days from the date of the event).

Example. You give birth to a child on March 24th. You submit the appropriate paperwork on April 15th to add your newborn to coverage under the USD #262 Valley Center Medical Plan. Your new election will be effective retroactively as of March 24th.

(2) All Other Changes. If your request relates to any other type of event, your request will not take effect until the first day of the month coincident with or next following the event, assuming you have completed this form and the Benefit Election and Salary Reduction Agreement. If you timely turn in your forms after the event and after the first business day of the month, your election will not take effect until the first day of the next month.

Example. You are married on January 15th. You submit the appropriate paperwork on January 20th to add your spouse to coverage. The change will take effect February 1. If, on the other hand, you do not submit the completed paperwork until February 5th, your new election will not take effect until March 1st.

REASON YOU WOULD LIKE TO MAKE A CHANGE

HIPAA SPECIAL ENROLLMENT EVENT: ***(Applies only to medical benefits)***

If any of the following events occur, you may change your election under the medical benefits in order to add coverage for yourself, your spouse, and/or your dependents. These are known as "HIPAA special enrollment rights." Please check the appropriate box below if you have experienced a HIPAA special enrollment event and you would like to change your coverage (including changing a coverage option) under the medical benefits:

☐ Loss of coverage under another group health plan

☐ New spouse through marriage

☐ New dependent through birth or adoption

☐ Loss of eligibility for Medicaid or a State's children's health insurance program (SCHIP)

☐ Become eligible for a State premium assistance subsidy from either Medicaid or SCHIP

ALL OTHER EVENTS:

(1) CHANGE IN NUMBER & ELIGIBILITY OF YOUR DEPENDENT CHILD(REN)

- □ Marriage
- □ Divorce, legal separation, or annulment *(must provide documentation)*
- □ Death of spouse

(2) CHANGE IN NUMBER & ELIGIBILITY OF YOUR DEPENDENT CHILD(REN)

- □ Birth or adoption of a child *(must provide documentation of adoption)*
- □ Change in "dependent" status (e.g., age, marriage, obtain full-time employment, no longer lives with you)
- □ Death of dependent

(3) CHANGE IN EMPLOYMENT STATUS *(if it affects benefits eligibility)*

	You	Spouse/Dependent
□ Change from part-time without benefits to part-time with benefits or full-time	____	____
□ Change from full-time or part-time with benefits to part-time without benefits	____	____
□ Beginning of Family and Medical Leave ("FMLA")	____	N/A
□ Return from Family and Medical Leave ("FMLA")	____	N/A
□ Beginning of an unpaid leave of absence	____	____
□ Returning from unpaid leave of absence	____	____
□ Change in worksite	____	____
□ Salaried to hourly pay	____	____
□ Hourly to salaried pay	____	____
□ Termination of employment	____	____
□ Beginning of employment	____	____

Name of dependent: _____

(4) CHANGE FROM 30 OR MORE HOURS PER WEEK TO LESS THAN 30 HOURS PER WEEK *(only applies to group health plans other than a health FSA and eligibility for the group health plan is not affected by the reduction in hours worked)*

- □ Revoke coverage in the following plan(s)*:_____

*In order to make an election change under this option, you (and, if applicable, your Spouse and/or dependents) must enroll in other minimum essential coverage that takes effect no later than the first day of the second month following the month in which you revoke your election under this plan.

(5) CHANGE IN COVERAGE (DOES NOT APPLY TO HEALTH FSA)

- □ Addition or significant improvement of a benefit package option

- □ Change in coverage under "another employer plan" (Employer, here, means my spouse's or dependent's employer, *or*, another of my employer's plans, if applicable) *and* that other plan permits a change for a reason that can be found on this form

- □ Open enrollment under "another employer plan" (Employer, here, means my spouse's or dependent's employer, *or*, another of my employer's plans) *and* my plan allows me to make an election for a period of coverage that is different from the period of coverage under the other plan

- □ Significant reduction in coverage, but *coverage is not lost*

    - □ Significant increase in the deductible
    - □ Significant increase in the co-pay
    - □ Significant increase in the out-of-pocket cost sharing limit
    - □ Other reduction, constituting an *overall* reduction in coverage (specify):_____

□ Significant reduction in coverage *resulting in a complete loss of coverage*

- □ Elimination of a benefit option
- □ HMO ceasing to be available in the area where I reside
- □ Overall lifetime or annual limitation
- □ Substantial decrease in the medical care providers available under the option
- □ Reduction in the benefits for a specific type of medical condition or treatment with respect to which: ___ I am, ___ my spouse is, ___ a dependent is (Name: _____) currently in a course of treatment.
- □ Other reason that has resulted in a fundamental loss of coverage (specify): _____

□ Loss of coverage under any group health coverage sponsored by a governmental or educational institution, such as one of the following (*please check*):

- □ State Children's Health Insurance Program ("SCHIP")
- □ A medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization
- □ A State health benefits risk pool
- □ A Foreign government group health plan
- □ Other: _____

(6) CHANGE IN COST OF COVERAGE (DOES NOT APPLY TO HEALTH FSA)

- □ Significant *increase* in the cost of my benefit package option
- □ Significant *decrease* in the cost of my benefit package option

(7) DEPENDENT CARE ASSISTANCE PLAN ("DCAP")

- □ Adding a daycare provider or changing daycare providers
- □ Change in hours of dependent care
- □ Coverage under spouse's or dependent's DCAP decreases or ceases
- □ Dependent's enrollment in school has decreased the necessary hours for daycare for *(name)*: _____
- □ Significant *increase* in the cost of the dependent care provider (except no change can be made where the cost change is imposed by a dependent care provider who is a relative)
- □ Significant *decrease* in the cost of the dependent care provider (such that you want to make an election)

(8) OTHER (DOES NOT APPLY TO DCAP ELECTION)

- □ Change in residence *(if it affects benefits eligibility)*
- □ Issuance of Judgment, Decree, or Order (relating to medical coverage)
- □ Entitlement to Medicare or Medicaid is ___ lost ___ gained
- □ Enrollment in a "qualified health plan" through the Marketplace due to a special enrollment event or the Marketplace's annual open enrollment period *(does not apply to a health FSA)*

DATE OF EVENT

Please provide the date for each event that you marked above:

Event: _____ Date of Event: _____

Event: _____ Date of Event: _____

By signing below, I understand and agree to the following:

- An election change may be made only if it is permitted under the terms of the Plan and under the terms of Section 125 of the Internal Revenue Code.

- The Plan Administrator may require me to provide appropriate documentation for any event(s) I have marked.

- The Plan Administrator must review and approve any change before it is given effect. The Plan Administrator, in his or her sole discretion, will make election change determinations.

- ***I have 30 days from the date of the event to turn in my forms; provided, however, that I have 60 days to turn in my forms if the election change event is a HIPAA special enrollment right related to eligibility for a State premium assistance subsidy or related to a loss of eligibility for Medicaid or SCHIP (see box on page 1).*** If the Plan Administrator determines that I have a valid election change event and the requested change is on account of and consistent with the event, my new election will take effect the first day of the month coincident with or next following the later of the date of the event or the date of the submission of my completed Request to Change Pre-Tax Elections form and Benefit Election and Salary Reduction Agreement. If, however, the event is the birth or adoption of my child, retroactive enrollment in the medical benefit is permitted.

  Note: In certain instances, such as the loss of dependent eligibility status, enrollment in certain benefits ends immediately, thereby requiring retroactive termination of coverage. Your dollar election, however, may only be changed prospectively. Thus, if you can anticipate the occurrence of a valid election change event (e.g., the birthday of a dependent, the upcoming hire date of a dependent for a full-time job), then you should submit your completed form and the Benefit Election and Salary Reduction Agreement prior to the date your salary will be reduced to pay for such coverage.

- The statements I have made on this form, including the boxes I have checked, are true and accurate.

_____ _____

(*Participant's Signature*) *(Date Submitted)*

RETURN COMPLETED FORM TO:

USD #262 Valley Center
Employee Benefits Department
143 S. Meridian Ave.
Valley Center, KS 67147
Fax: (316) 755-7001

For internal use only:

Decision: □ Denied □ Accepted with respect to _____ benefit for _____.
(Benefit) *(Name of Individual)*
□ Denied □ Accepted with respect to _____ benefit for _____.
(Benefit) *(Name of Individual)*

Reason for Denial *(if applicable)*: _____.

Accepted and Agreed to: _____ _____
(Plan Administrator's Signature) *(Date)*

Effective: ____ / ____ / 20___

INITIAL NOTICE OF COBRA RIGHTS

INTRODUCTION

You are receiving this Initial Notice of COBRA Rights (the "Notice") because you have recently become covered under the **USD #262 Valley Center Medical Plan, USD #262 Valley Center Dental Plan, USD #262 Valley Center Vision Plan, and/or USD #262 Valley Center Health Flexible Spending Account** (collectively known hereinafter as the "Plan"). This Notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end.

This Notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This Notice gives only a summary of your COBRA continuation coverage rights. The Plan provides no greater COBRA rights than what COBRA requires – and nothing in this Notice is intended to expand your rights beyond COBRA's requirements. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description *or* contact the Plan Administrator.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

The name, address, and telephone number of the Plan Administrator are as follows:

USD #262 Valley Center
143 S. Meridian Ave.
Valley Center, KS 67147
(316) 755-7000

The Plan Administrator has the responsibility for administering COBRA continuation coverage, but may have contracted with a third-party administrator to carry out the day-to-day COBRA administrative functions on behalf of the Employer. The party responsible for administering day-to-day COBRA administrative functions, or that party's address and telephone number, may change from time to time. You should consult the Plan Administrator or Summary Plan Description for the most current address if the COBRA administrator changes.

COBRA CONTINUATION COVERAGE

COBRA coverage is a continuation of coverage under the Plan when the coverage would otherwise end because of an event known as a "qualifying event." Specific qualifying events are listed later in this Notice. After a qualifying event, COBRA coverage must be offered to each person who is a "qualified beneficiary." You, your covered spouse, and your covered dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event.[1] Under the Plan, qualified beneficiaries who elect COBRA coverage must pay the cost of COBRA coverage.

Employee. If you are an employee, you will become a qualified beneficiary *if* you lose your coverage under the Plan because either one of the following qualifying events takes place:

(1) Your hours of employment are reduced so that you are no longer eligible for coverage; or

(2) Your employment ends for any reason other than your gross misconduct.

Spouse. If you are the spouse of an employee, you will become a qualified beneficiary *if* you lose your coverage under the Plan because any one of the following qualifying events takes place:

(1) Your spouse dies;

(2) Your spouse's hours of employment are reduced so that you are no longer eligible for coverage;

(3) Your spouse's employment ends for any reason other than for gross misconduct;

(4) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

(5) You become divorced or legally separated from your spouse.[2]

Dependent Child. Your dependent children will become qualified beneficiaries *if* they will lose coverage under the Plan because any one of the following qualifying events takes place:

(1) The parent-employee dies;

(2) The parent-employee's hours of employment are reduced so that you are no longer eligible for coverage;

(3) The parent-employee's employment ends for any reason other than for gross misconduct;

---

[1] Certain newborns, newly-adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.

[2] If your spouse cancels coverage for you in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though you lost coverage earlier. You must notify the administrator within 60 days after the divorce or legal separation and establish that your ex-spouse, the employee, canceled the coverage earlier in anticipation of the divorce or legal separation in order for COBRA coverage to be made available for the period after the divorce or legal separation.

(4) The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);

(5) The parents become divorced or legally separated; or

(6) The child no longer satisfies the definition of a "dependent child" under the Plan.

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 retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Each qualified beneficiary will have an independent right to elect COBRA. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all the qualified beneficiaries, and parents may elect COBRA on behalf of their children.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. A qualified beneficiary's COBRA coverage will terminate automatically, however, if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health coverage.

– IMPORTANT –

The Plan will offer COBRA coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. For each qualified beneficiary who timely elects COBRA coverage, COBRA coverage will begin on the first of the month following the date of the qualifying event.

When the qualifying event is the end of employment, a reduction in hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event.

For all other qualifying events – that is, divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child – *you must notify the Plan Administrator* in writing within 60 days after *the later of* the qualifying event *or* the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

You must follow the Plan's reasonable procedures for providing notice which are found on the last two pages of this Notice and in your Summary Plan Description. If these procedures are not followed or if notice is not provided in writing to the Plan Administrator during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage.

MAXIMUM PERIOD OF COVERAGE UNDER THE PLAN

The duration of the maximum period of COBRA coverage will vary depending on (1) the qualifying event and (2) whether or not there is a second qualifying event or a disability extension. The following are COBRA qualifying events if they are coupled with a loss of coverage under the Plan. The maximum period of coverage permitted under COBRA is listed along with each event:

(1) **Death of the employee –** COBRA continuation coverage may last for up to 36 months for the spouse and any dependents who are qualified beneficiaries.

(2) **Employee becomes entitled to Medicare (under Part A, Part B, or both) –**

(A) COBRA continuation coverage may last for up to 36 months for the spouse and any dependents who are qualified beneficiaries.

(B) See the examples under qualifying events (5) and (6) below for how an employee's entitlement to Medicare may affect the spouse's or dependent child's maximum coverage period when coverage has been lost due to the employee's termination of employment or reduction in hours.

(3) **Divorce or legal separation –**

(A) COBRA continuation coverage may last for up to 36 months for the spouse and any dependents who are qualified beneficiaries.

(B) *Example.* A covered employee and his spouse divorce. If the Plan Administer is timely and appropriately notified of the divorce, the spouse, who would otherwise lose coverage, may elect COBRA coverage if it is elected within 60 days after the later of the divorce or the loss of coverage in accordance with the Plan's reasonable procedures for providing notice. Any dependent child, who was also covered at the time of the divorce and who will otherwise lose coverage due to the divorce, may also elect COBRA coverage.

(4) **Dependent child losing eligibility as a dependent child –**

(A) COBRA continuation coverage may last for up to 36 months for the dependent who is a qualified beneficiary.

(B) *Example.* A dependent child is covered under the Plan. The dependent child turns age 26. As a result, the dependent child will "age-out" of the Plan and lose coverage at the end of the month. Following the Plan's reasonable procedures for providing notice as found in the Summary Plan Description, however, COBRA coverage is timely elected and the individual is given 36 months of continuation coverage.

(5) **Termination of employment –**

(A) COBRA continuation coverage may last for up to 18 months for the former employee, the spouse and any dependents who are qualified beneficiaries.

(B) The 18-month period for the spouse and/or dependent child may be extended if there is a "second qualifying event." See (7) below.

(C) If the employee became entitled to Medicare benefits less than 18 months before his or her termination of employment, COBRA coverage for qualified beneficiaries other than the employee may last until 36 months after the date of Medicare entitlement.

(i) *Example*. A covered employee became entitled to Medicare eight (8) months before the date on which his employment terminated. COBRA coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which, in this case, is equal to 28 months after the date of his termination (36 months minus 8 months).

(6) **A reduction in the employee's hours of employment, causing the employee to lose eligibility for coverage –**

(A) COBRA coverage may last for up to 18 months for the employee, spouse and any dependents who are qualified beneficiaries.

(B) The 18-month period may be extended if there is a "second qualifying event." See (7) below.

(C) If the employee became entitled to Medicare benefits less than 18 months before coverage is lost due to a reduction in hours of employment, COBRA coverage for qualified beneficiaries other than the employee may last until 36 months after the date of Medicare entitlement.

(i) *Example*. A covered employee became entitled to Medicare eight (8) months before the date on which he stopped being eligible for coverage due to a drop in the number of hours employed. COBRA coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which, in this case, is equal to 28 months after the date of the reduction in hours (36 months minus 8 months).

(7) **Second Qualifying Event –**

(A) If the employee's family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described below), the spouse and dependent children (along with certain newborns and newly adopted children) can get up to 18 additional months of COBRA coverage, for a maximum of 36 months. In order for this to occur, the following requirements must be met:

(i) The spouse and dependent children must be qualified beneficiaries who have elected and paid for COBRA coverage.

(ii) COBRA coverage is still in effect for the qualified beneficiaries at the time of the second qualifying event.

(iii) The event is one that would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

(iv) The Plan Administrator is notified in writing of the second qualifying event within 60 days of the second qualifying event. The Plan requires you to follow its reasonable procedures for providing notice as found in the Summary Plan Description.

(B) **If the notice procedures are not followed or if the notice is not provided in writing to the Plan Administrator within the required period, then there will be no extension of COBRA continuation coverage due to a second qualifying event.**

(8) **Disability Extension –**

(A) COBRA coverage may be extended from 18 months to 29 months.

(B) If the covered employee or anyone in his/her family covered under the Plan is determined by the Social Security Administration to be disabled and the Plan Administrator is notified in a timely fashion, the covered employee and his/her entire family (along with certain newborns and newly adopted children) may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months.

(C) In order to receive the disability extension, each individual must be a qualified beneficiary who has elected and is paying for COBRA coverage and whose COBRA coverage is still in effect at the time of the disability determination.

(D) The disability must have started some time before the 61st day of COBRA coverage and must last at least until the end of the 18-month period of continuation coverage.

(E) The Plan Administrator must be notified in writing of the Social Security Administration's determination within 60 days after the latest of (a) the date of the determination, (b) the date of the covered employee's termination or reduction of hours, and (c) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours. In addition, notice must be given before the end of the 18-month period of COBRA coverage.

(F) You must follow the Plan's procedures providing notice. **If these procedures are not followed or if notice is not provided in writing to the Plan Administrator within the required period, then there will be no disability extension of COBRA continuation coverage.**

SPECIAL RULES FOR HEALTH FSA

COBRA coverage under a health flexible spending account ("Health FSA") maintained by the Employer will only be offered to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if he or she has been reimbursed for an amount that is less than his or her contributions through the time of the qualifying event. In addition, the use-it-or-lose-it rule will continue to apply, so any unused amount will be forfeited at the end of the plan year. Finally, COBRA coverage will end on the *last day of the plan year* in which the qualifying event occurred, regardless of the qualifying event.

Each beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate annual limit and a separate premium. If you are interested in this alternative, contact the Plan Administrator for more information.

Other Coverage Options In Addition To COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, a qualified beneficiary may have other coverage options during a "special enrollment period" through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan). Some of these options may cost less than COBRA continuation coverage. More information about these options is available at www.healthcare.gov.

Children Born To Or Placed For Adoption With The Covered Employee During COBRA Period

A child born to, adopted by, or placed for adoption with a covered employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee 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 employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (e.g., regarding age).

Alternate Recipients Under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order ("QMCSO") received by the Employer during the covered employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

If You Have Questions

Questions concerning your Plan or your COBRA rights should be addressed to the Plan Administrator's address as indicated on the first page of this Notice.

Keep Your Plan Informed Of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any change in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

COBRA NOTICE PROCEDURES

Warning: If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable). If COBRA coverage should have been terminated but was not, due to a lack of notice from a qualified beneficiary, the Employer will immediately terminate coverage and require payment to the Plan of all benefits paid after what should have been the termination date.

Notices Must Be In Writing And Submitted On Plan Forms: Any notice that you provide must be in writing and must be submitted on the Plan's required form. (You the may obtain copies of required forms from the Plan Administrator). Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable.

How, When, And Where To Send Notices: You must mail or hand-deliver your notice to the Plan Administrator, whose address is provided on the first page of this Notice.

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the Plan Administrator individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice periods are described above in this Notice and in your Summary Plan Description.)

Information Required For All Notices: Any notice you provide must include: (1) the name of the Plan; (2) the name and address of the employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required For Notice of Divorce Or Legal Separation: If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the Plan Administrator that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the Plan Administrator that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Additional Information Required For Notice Of Disability: Any notice of disability must include: (1) the name and address of the disabled qualified beneficiary; (2) the date that the qualified beneficiary became disabled; (3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination; (5) a copy of the Social Security Administration's determination; and (6) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

Additional Information Required For Notice Of Second Qualifying Event: Any notice of a second qualifying event must include: (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

Who May Provide Notices: The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice of the qualifying event, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

CHECKLISTS

CHECKLIST OF DOCUMENTS TO BE DISTRIBUTED TO PARTICIPANTS UPON BECOMING ELIGIBLE TO PARTICIPATE IN THE PLAN

The following documents should be given to participants at the time they become eligible to participate in the Plan:

1) Summary Plan Description

This is a summary of the main provisions of the Plan. It is recommended that the SPD be distributed to new participants immediately.

2) Pre-Tax Benefit Election and Salary Reduction Agreement

This form is used by the participant to elect in which benefits under the Plan the participant would like to participate and have his or her compensation reduced in order to pay for his or her share of the cost of such benefits on a pre-tax basis. In addition, the form allows the participant to specify how much of his or her salary he or she would like to contribute to the health flexible spending account and/or the dependent care assistance plan. The form also authorizes the company to reduce the participant's compensation and it explains how often the participant can revoke or change the election.

The participant should complete and return this form to the Plan Administrator.

3) After-Tax Benefit Election and Salary Reduction Agreement

This form is used by the participant to elect in which benefits under the Plan the participant would like to participate and have money deducted from his or her compensation in order to pay for such benefits on an after-tax basis. It also authorizes the company to make such deductions and explains how often the participant can revoke or change the election.

The participant should complete and return this form to the Plan Administrator.

4) Initial COBRA Notice

Federal law requires that a notice explaining COBRA rights be given to all covered employees and their spouses participating in group health plans. It is recommended that you send the Initial COBRA Notice via first class mail addressed to the covered employee and the covered employee's spouse (if the spouse is also covered under the Plan). For example, if Jane Smith is your employee, both she and her husband John Smith are covered under your plan, and they are both living at the same address, an Initial COBRA Notice should be mailed either to "Mr. and

Mrs. John Smith" or to "John and Jane Smith." This should be done as soon as possible so that they are aware of their notice obligations to notify the plan administrator if certain events take place, such as a divorce or legal separation. Separate mailings should be made if the employee and spouse live at different addresses. If you give the Notice to an employee at the workplace, you should mail a separate copy to the employee's spouse.

5) HIPAA Privacy Notice

A HIPAA Privacy Notice must be given to the participant if he is enrolled in the health flexible spending account. This notice informs the participant how his or her "protected health information" may be used or disclosed and it explains their individual rights with regard to "protected health information."

A HIPAA Privacy Notice must be given to a participant in the Medical Plan or Dental Plan upon request. This notice informs the participant how his or her "protected health information" may be used or disclosed and it explains their individual rights with regard to "protected health information." You do not need to distribute this Notice at enrollment time because the Medical Plan and Dental Plan are fully-insured and the insurance company must provide this for you.

6) Other

Any other forms required by the insurance company for an insured plan.

CHECKLIST OF DOCUMENTS TO BE DISTRIBUTED TO PARTICIPANTS UPON TERMINATION OF PARTICIPATION IN ONE OR MORE PLANS

COBRA

A COBRA Election Notice should be given to participants at the time they terminate participation in the Medical Plan, Dental Plan, Vision Plan or Health Flexible Spending Account* if participation is terminated due to one of the following COBRA triggering events:

(1) Termination of employment
(2) Reduction in hours (but only if it results in a loss of eligibility)
(3) Divorce
(4) Loss of dependent status
(5) Entitlement to Medicare
(6) Death of the Employee-Participant
(7) Bankruptcy of the Employer

It is recommended that you send the COBRA Election Notice via first class mail to all participants who have lost coverage. A single notice may be sent to an employee, his or her spouse, and any dependent-children that were covered if they are all living at the same address. If, however, the COBRA qualifying event is the loss of dependent status, we recommend mailing separate notices to the covered employee (or spouse) and the dependent who is losing coverage even if they live at the same address. Separate mailings should be made if the employee, spouse, and/or dependents live at different addresses.

If a Participant decides to continue coverage, the Participant should also refer to his or her table of COBRA procedures, which is an appendix to the SPD, to determine what qualifies as a "second qualifying event" after termination of employment or a reduction in hours. Participants may be allowed to extend the maximum length of their COBRA period if the procedures are correctly and timely followed. If a Participant has misplaced his or her COBRA procedures, you should provide them with another copy at this time.

OTHER

Any other forms required by the insurance company for an insured plan.

*Only participants with money left in their Health FSA should receive an election notice.