

NEOSHO R-5 SCHOOL DISTRICT

EMPLOYEE HEALTH CARE PLAN PLAN DESCRIPTION

This booklet is the Plan Document, which defines your benefits provided by Neosho R-5 School District. It is written so that it can be used by you, the Plan Administrator and Claims Supervisor in administering the Plan. Any definitions or policies not detailed in this document are referenced in the "Trilogy Claims Administrative Handbook", which is available for your review at Benefit Management, Inc. All claims to be filed or inquiries regarding such claims should be directed to Benefit Management, Inc., P.O. Box 3001, Joplin, Missouri 64803, (417) 782-1515 or (888) 294-1515.

MEDICAL PLAN CONCEPTS

Preferred Providers

This Plan is contracted with Providers for preferred pricing for services to the covered members. Contracting Providers are referred to as In-Network Providers and Non-contracting Providers are referred to as Out-of-Network providers. To receive the maximum benefits allowable under the Plan, you must use In-Network Providers. Service and products rendered by Non-Network Providers for a life or limb threatening condition requiring Medical Emergency treatment will be paid at the Network level of benefits until the patient is stabilized or can be safely transferred.

Pre-Certification

Pre-Certification is required for all Inpatient Hospital stays. Upon learning that he or she will be hospitalized, the covered Plan member must notify the Pre-Certification service prior to, or at the time of his/her hospitalization. He/she will be required to give the physician's name and telephone number and the group number, which is 8500. The number to call is (800) 989-1115, and is also displayed on your personal ID Card. The Physician or Hospital may provide notification, but the responsibility of contacting the Pre-Certification department rests with the Plan member. All Inpatient Hospital days which are not certified as Medically Necessary will not be covered.

Failure to obtain Pre-Certification will result in a 20% reduction in benefits, not to exceed \$2,000 per calendar year. In the case of an emergency, a Pre-Certification penalty will not be applied if the patient or Physician notifies the Pre-Certification department within forty eight (48) hours or the next business day following hospitalization, to provide the necessary review information. Longer stays than were originally Pre-Certified will require follow-up review by the Pre-Certification department. If the Pre-Certification department disagrees with the additional days requested by the Physician, the patient, Hospital and Physician will be advised. Pre-Certification does not guarantee payment of Benefits. All other Plan provisions, limits and exclusions apply to Pre-Certified Hospital admissions.

Case Management

Case Management helps Physicians and patients to identify ways in which patients with serious illnesses or special needs can be treated in a cost-effective manner in a Hospital setting or at home, including assistance in negotiating preferred rates with providers. A Case Management Specialist is available through the Utilization Management department. As defined in the Plan, services can be paid if recommended by the Physician and where Case Management and a Physician are in agreement.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment plan is individually tailored to a

specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Pre-Existing Conditions

Under certain circumstances, the Plan will not provide benefits for pre-existing medical conditions. This pre-existing condition period will last for 12 months from your coverage effective date. It will apply to any condition for which medical advice, diagnosis, care or treatment was either received or recommended during the six months prior to your enrollment date.

Compliance

A new federal law imposes certain requirements on group health plans. Under this new federal law, a group health plan is limited in imposing pre-existing conditions exclusions on new enrollees, who had prior creditable coverage. As part of the new federal law, plan sponsors of Non-Federal Government plans can elect to be exempt from the above-mentioned requirements. Carthage R-9 School District has elected exemption from this requirement.

DEDUCTIBLES, CO-PAYS & CO-INSURANCE

Deductibles, Individual & Family

Each Plan member is responsible for payment of eligible charges up to the amount of his/her deductible. The In-Network calendar year deductible amount is \$600 per individual and \$1,200 per family. The Out-of-Network deductible is \$1,000 per individual and \$2,000 per family. Charges which are incurred during the last three months of any calendar year and applied to deductible, will be credited toward the next year’s deductible amount.

Co-Insurance

After deductible and basic benefits have been considered, the Plan member is required to pay a percentage of charges called “Co-insurance”. The Plan pays the following percentages:

Schedule of Benefits

Service or care Provided	In-Network	Out-of-Network
Physician Office Visits	100% after \$20 co-payment	50% after deductible
Room & Board	90% after deductible	50% after deductible
Intensive Care Services	90% Hospital ICU Charge	50% Hospital ICU Charge
Skilled Nursing Unit	90% after deductible 90 days Max per calendar year	50% after deductible 90 days Max per calendar year
Physician Services (Inpatient)	90% after deductible	50% after deductible
Surgery	90% after deductible	50% after deductible
Ambulance Service	90% after deductible	50% after deductible
Emergency Room	90%	50%

Urgent Care	100% after \$50 Co-payment	100% after \$50 C-payment
Home Health	90% after deductible	50% after deductible
Hospice Care	90% after deductible	50% after deductible
Physical, Speech and Occupational Therapy	100% after \$20.00 co-payment 40 visit Max per calendar yr	50% after deductible 40 visit Max per calendar yr
Mammograms	100% after \$20 co-payment	50% after deductible
Chiropractic Care (Wellness & Massages are not covered)	80% after deductible \$500 per calendar year Max	80% after deductible \$500 per calendar year Max
Wellness Benefits: Adult & Child	100% after \$20 co-payment \$300 calendar year max	50% after deductible \$300 calendar year max
Diabetes Self-Management	100% after \$20 co-payment \$452 calendar year max	
Durable Medical Equipment	90% after deductible	50% after deductible
Prosthetics	90% after deductible	50% after deductible
Orthotics	90% after deductible	50% after deductible
Organ Transplants	90% after deductible \$500,000 lifetime Max \$10,000 Donor Lifetime Max	50% after deductible \$500,000 lifetime Max \$10,000 Donor Lifetime Max
Inpatient Mental Health	90% 30 days Max per Calendar Year	50% 30 days Max per Calendar Year
Outpatient Mental Health	100% after \$25 co-payment 20 days Max per Calendar Year	100% after \$25 co-payment 20 days Max per Calendar Year
Inpatient Substance Abuse	90% 30 days Max per Calendar Year	50% 30 days Max per Calendar Year
Outpatient Substance Abuse	100% after \$25 co-payment 20 visits Max per Calendar Year	100% after \$25 co-payment 20 visits Max per Calendar Year
Pregnancy	100% of first office visit after \$20 co-payment. Any services performed after first office visit are subject to deductible and co-payment percentages.	50%

Co-insurance Maximum

The In-Network Co-insurance Maximum is \$2,000 per individual and \$4,000 per family and Out-of-Network is \$10,000 per individual and \$20,000 per family. The Plan will pay the designated percentage of covered charges until the out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the Calendar Year unless stated otherwise. The following charges do not apply toward the co-payment maximum and are never paid at 100%.

- Deductible(s)
- Outpatient Mental Treatment charges
- Outpatient Substance Abuse Treatment charges
- Cost containment penalties
- Physician office visit or Lab One Co-payments
- Prescription Drug Co-payments

The Plan has a per member lifetime maximum for all benefits of \$2,000,000.

EXPLANATION OF MEDICAL BENEFITS

Medical Necessity

The Plan will pay for eligible charges submitted when determined to be Medically Necessary for the diagnosis or treatment of an Injury or Illness for which symptoms are present. If the requested charges are not determined to be Medically Necessary or if the charges are not identified as an established, effective medical procedure, the charges will be excluded from coverage, unless covered under the Plan's Routine Care provisions.

Inpatient Services

The following are covered benefits for inpatient hospital services, where the patient is admitted for an overnight stay (more than 23 hours):

- Intensive and cardiac care
- Semi-private room
- Private room charges where semi-private rooms are not available
- Private room charges will be considered at the semi-private room rate in the hospital where the patient is confined
- Operating room and delivery room
- Surgical preparatory room
- Oxygen and its administration
- Anesthesia and recovery
- Dressings, splints, medical supplies and casts
- Radiation therapy
- Skilled Nursing (up to 90 days per calendar year)
- Hospital ancillary charges other than room and board and deemed medically necessary
- Mental health and substance abuse treatment (annual limitations apply)

Outpatient Services

The following are covered services for outpatient procedures, which may occur at a hospital, physicians office, or other medical setting.

- Physicians fees for diagnosis, treatment and surgery;
- Charges made by a licensed physiotherapist if prescribed by a Physician;
- Diagnostic x-ray and laboratory services;
- Charges for pregnancy, childbirth or miscarriage, unless the patient is covered as a Dependent child under the Plan;
- Emergency room charges;
- Radiation therapy, chemotherapy and radioactive isotopes;
- Hemodialysis;

- Ambulatory surgical center services;
- Outpatient surgery charges, anesthesia and anesthesia recovery room;
- Hospice and Home Health Services;
- Oral surgery to remove impacted wisdom teeth;
- Second Surgery Opinions; and
- Occupational, Physical, or Speech therapy by a licensed therapist.

Physician Office Visits (PPO Providers Only)

In-Network Office Visits are covered at 100% after a \$20 per visit co-payment. Surgery and Lab and X-ray charges are not included in this benefit. Out-of Network providers are subject to deductible and coinsurance.

Laboratory and X-Ray Charges

The Plan has contracted with LabOne. When services are received at a LabOne facility, the Plan will pay at 100%. All other Medically Necessary Laboratory and X-ray charges are covered at 90% In-Network and 50% Out-of-Network and are subject to the deductible and coinsurance.

Routine Examinations

Office visit charges for routine examinations, including adult immunizations, are covered at 100% after a \$20.00 co-payment for In-Network providers and have a maximum benefit of \$300 per year for persons age 19 or over. Out-of-Network providers are covered at 50% and subject to deductible and coinsurance. Lab and X-ray charges are not included other than Pap Smears. This benefit does not include charges for MRI, CAT, PET or Mammography imaging.

Routine Mammography Services

Routine mammography services received by non-symptomatic women for screening purposes are covered by the Plan. Benefits will be provided subject to deductible and coinsurance provisions of the Plan. Limitations on the frequency of this service are as follows.

- Age 35 through 39, one mammogram;
- Age 40 through 49, one mammogram biennially or more frequent if recommended by a Physician; and
- Age 50 and over, one mammogram annually.

Regardless of age, women who have a history of breast cancer, or whose Mother or Sister has a prior history of breast cancer may receive one annual mammogram if recommended by their Physician.

Childhood Preventive Care/Routine Childhood Immunizations

The Plan provides coverage at 100% after a \$20 co-payment for pediatric routine immunizations administered to a Dependent child through age 18. This applies to office visit and any other services during office visit. Out-of-Network is covered at 50% and subject to deductible and coinsurance. The Calendar Year Maximum is \$300. Immunizations for the purpose of travel are not covered.

Emergency Room

Benefits are subject to annual deductible and coinsurance. The utilization review administrator must be notified within 48 hours of a hospital admission, even if the patient is discharged within 48 hours of admission.

Urgent Care

If the Urgent Care facility is utilized, the Covered Person will be charged a \$50.00 co-payment.

Mouth, Teeth and Gums

Injury to or care of mouth, teeth, gums and alveolar processes will be covered charges under Medical Benefits only if that care is for the following oral surgical procedures:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth;
- Emergency repair due to injury to sound natural teeth. This repair must be made within 12 months from the date of an accident;
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth;
- Excision of benign bony growths of the jaw and hard palate;
- External incision and drainage of cellulitis;
- Incision of sensory sinuses, salivary glands or ducts; or
- Removal of impacted teeth.

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

Ambulance Services

Emergency transportation by a local professional ground ambulance service to the nearest hospital facility equipped to treat the emergency. Emergency helicopter transportation will only be approved if documentation supports that the medical condition was life or limb threatening and could not safely be done by a ground ambulance. The Calendar Year Maximum benefit for Ambulance services is \$5,000.

Home Health Care

Payment for these services is subject to review by Case Management to identify medical criteria and cost-effective alternatives. The Plan will cover:

Charges for Home Health Care visits made by a Registered Graduate Nurse (R.N.), a Licensed Practical Nurse (L.P.N.), a home health aide, a physical therapist, an occupational therapist or a speech therapist, if provided in accordance with a home health care plan established by a doctor and recommended by case management.

A Home Health Care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of Home Health Aide services.

Home Health Care is limited to one visit per day up to 90 visits per Plan Year.

Hospice Care

The benefits include Inpatient and Outpatient Hospice Care, with a \$10,000 lifetime maximum. Charges must be Medically Necessary and for the treatment of a Plan member who has a diagnosed terminal illness, to include:

- Medications and drugs requiring a doctor's written prescription;
- Psychological counseling and therapy rendered solely to the Plan member by an M.D., Ph.D., or licensed social worker (M.S.W.);
- Rental, up to purchase price, of hospital-type equipment such as a hospital bed, oxygen or wheelchair; and

- Inpatient Palliative Care.

Medical Equipment and Supplies

The following are covered benefits under the Plan, provided they are prescribed by a Physician as a result of Illness, Disease or Injury and are deemed Medically Necessary. Prior approval is required for charges in excess of \$500.

- Oxygen and the rental or purchase of equipment for its administration;

- Rental (up to the purchase price) of a hospital-type bed, wheelchair, or similar durable medical equipment required for medical care or treatment which has no personal use in the absence of the condition for which prescribed;
- Orthotic appliances and prosthetic devices when prescribed by a physician and custom made. No coverage is provided for repair or replacement except when necessitated by normal wear or a change in medical condition;
- Benefits are also payable for the first pair of eyeglasses or contact lenses following cataract surgery;
- One breast prosthesis per breast following a mastectomy;
- One wig following radiation therapy to the head or following chemotherapy; and
- Two mastectomy bras per calendar year.

Mental Health

Inpatient Services: The Plan provides coverage for Inpatient Mental Health services received in a Hospital setting. The Plan pays 90% In-Network, up to a maximum of 30 days of Inpatient care per calendar year. Out-of-Network is covered at 50% and subject to Deductible and Coinsurance.

Outpatient Services: The Plan provides coverage for Outpatient Mental Health services received in a Hospital setting. There is a \$25 co-payment per visit up to a maximum of 20 days of Outpatient care per Calendar Year.

Substance Abuse

Inpatient Services: The Plan provides coverage for Inpatient Substance Abuse treatment received in a Hospital setting. It is covered at 90% up to a maximum of 30 days of Inpatient care per calendar year. Out-of-Network is covered at 50% and subject to deductible and coinsurance. Coverage is limited to acute phase of detoxification for drug or alcohol abuse only.

Outpatient Services: The Plan provides coverage for Outpatient Substance Abuse treatment received in a Hospital setting. There is a \$25 co-payment per visit up to a maximum of 20 visits of Outpatient care per calendar year. Coverage is limited to Diagnosis and treatment of medical conditions only.

Organ Transplants

All charges associated with tissue and organ transplants must be reviewed by Case Management prior to service, however the review may be waived in the case of an emergency. The following procedures are covered to a lifetime maximum of \$500,000;

- Charges for human organ and tissue transplants, limited to heart, lung, bone marrow, kidney, liver, cornea and pancreas, and other transplants which become non-experimental as determined by the Plan Administrator.
- Immunosuppressants used in connection with covered human organ and tissue transplants.

Donor related expenses including bone marrow acquisition and genetic testing are covered by the Plan as long as the transplant recipient is a covered participant.

All Experimental transplants are excluded from coverage, including Experimental bone marrow transplants. In the event of a dispute or appeal as to whether a transplant or related charges are considered experimental in nature, the final decision will be rendered by the Plan Administrator. Donor related charges are covered up to \$10,000 as long as the recipient is a covered Plan member.

Other Covered Charges

All other eligible charges are covered at 90% In-Network and 50% Out-of Network after the annual deductible and any applicable Basic Benefits are applied.

Prescription Drugs

All prescription drugs under the Plan require the written approval of a Physician and must be approved by the Federal Food and Drug Administration. Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Prescription benefits are limited to FDA and PDR approved quantities and uses. Maintenance medications are available in a 90-day supply if purchased through the Mail Order Drug Service. Order forms may be obtained by contacting your Human Resources Representative.

The following medications will require prior approval before benefits will be provided: Oxycontin and Tegaserod.

Each Covered Person must meet a separate prescription Deductible of \$100.00 per calendar year.

Regular prescription co-pays apply until the Plan has paid \$2,000 in prescription benefits in a calendar year. After the limit has been reached, the Plan will pay 50% of covered prescription costs.

Drug Card Co-Payments

Generic:	\$10.00
Name Brand:	\$25.00
Name Brand:(when Generic is available)	\$40.00 or 20% (whichever is greater)

Mail Order Co-Payments

Generic:	\$20.00
Name Brand:	\$50.00
Name Brand:(when Generic is available)	\$80.00 or 20% (whichever is greater)

EXCLUSIONS AND LIMITATIONS

Coverage under the Plan is limited to services incurred during the Plan year. The following are exclusions and limitations for which the Plan does not pay benefits, and shall apply to services described herein:

1. **Abortion**, when performed for any reason other than to prevent the death of a covered female.
2. **Acupuncture** and acupressure regardless of the type of provider.
3. **Alcohol** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol.
4. **Armed Forces** Injuries occurring while engaged in the services of any branch of Armed Forces or in any act of war whether declared or undeclared.
5. **Biofeedback** technique whereby one seeks to consciously regulate a bodily function by using an instrument to monitor and signal changes in the function.
6. **Breast Implant Removals**, except for post-mastectomy patients.
7. **Charges** for which payment is not required or charges which the covered person is not legally obliged to pay.

8. **Chelation Therapy** Charges for Chelation therapy, except for the treatment of heavy metal poisoning.
9. **Complications of non-covered treatments** Care, services or treatment required as a result of complications from a treatment not covered under the Plan, except complications from an abortion for a covered Employee or Spouse are covered.
10. **Contraceptive** devices or injections.
11. **Cosmetic Treatment**, which means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.
12. **Court Ordered Treatment** Charges for any care ordered by the Court or the Police Department.
13. **Custodial Care** (see definition of Custodial Care).
14. **Dental Care** to include oral surgery charges, unless due to an accident, which occurred while covered under this Plan, except as provided in the Explanation of Medical Benefits.
15. **Educational and/or Institutional** Charges for testing, training or education whether Inpatient or Outpatient, including services related to learning disabilities. Diabetic education will be covered. No treatment for services for development delay, learning disorders or speech delay.
16. **Exercise or Wellness programs** unless provided for by the Plan.
17. **Experimental or Investigational** Treatment to include charges for care, treatment, services or supplies that are experimental or investigational in nature. If reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of clinical trials, is in research, experimental, study or investigation arm of on-going clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis, will be considered experimental and investigational.
18. **Foot Care** Treatment or service with respect to corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet, casting for orthotics, strapping or any appliance (including orthotics), except for the treatment needed for metabolic (Diabetic) or Peripheral-vascular disease.
19. **Foreign Travel** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
20. **Gastric Bypass**
21. **Growth Hormone** Charges incurred for testing or diagnosis over the age of 18 and any related lab charges and medications.
22. **Hair Loss** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
23. **Hazardous Hobby** Care and treatment of an Injury or Sickness that originates from the pursuit of additional interests or hobbies of a hazardous nature, specifically, skydiving, hang gliding, bungee cord jumping, or aeronautical device; from

competition involving pay, profit or gain, including, but not limited to, organized motor vehicle racing, boat racing or participating in a rodeo.

24. **Hearing Aids**, devices, exams, fittings and repair.
25. **Hearing Loss** Any treatment, care or surgical procedures for persons over the age of 50, if it is correctable with the use of a hearing aid. Sensory hearing loss is excluded.
26. **Homeopathic and Alternative Medicine**
27. **Hospital Employees** Professional services billed by a Physician or nurse who is an Employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
28. **Illegal Acts** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance.
29. **Illegal Drugs or Medications** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances.
30. **Immediate Family** Charges from a provider who usually resides in the same household as the covered person, or who is a member of his/her immediate family or the family of his/her spouse.
31. **Infertility Services/Artificial Insemination** Charges for in-vitro fertilization procedures or drugs, GIFT (Gamete Intra-Fallopian Transfer) procedures, artificial insemination, or other procedures, studies or drugs related to the treatment or diagnosis of infertility, except for surgical charges in connection with sterilization (the Plan will not pay for the reversal of a sterilization).
32. **Maternity** related charges incurred by a Dependent child to include all charges for the newborn child.
33. **Medically Unnecessary** Services which are not medically necessary for the diagnosis or treatment of a condition with which symptoms are not present, including, but not limited to colonoscopies and bone density tests, except for one sonogram per pregnancy and Diabetic supplies and monitoring devices.
34. **Medical Records** to include payment for any records or documents associated with a request for enrollment in the Plan, determination of eligible charges, or any appeal by a Plan member.
35. **Mental Health Treatment** to include the treatment of nervous or mental disorders in excess of the Plan limitations;
36. **No obligation to pay** Charges incurred for which the Plan has no legal obligation to pay.
37. **No Physician recommendation** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

38. **Non-emergency Hospital Admissions** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
39. **Non-Physician Care** or charges for care or services not provided by a covered provider.
40. **Non-Reasonable and Customary Charges** which are in excess of the Allowable/Reasonable and Customary charges for services and materials as determined by Ingenix and Benefit Management, Inc.
41. **Not specified as covered** Services, treatments and supplies which are not specified as covered under this Plan.
42. **Nutrition** Any nutrition, (even if only source of nutrition) such as tube feedings or special diets, including nutritional supplements.
43. **Over-the-Counter Medication**
44. **Personal Comfort Items** such as TV, telephone, air conditioning, humidifiers, physical fitness equipment and items generally useful outside the Hospital.
45. **Physician Care**, which is not within the scope of his/her license.
46. **Private Duty Nursing Charges**

47. **Pre-Existing Conditions** for which a Plan member has sought out professional advice, treatment, or has had medication prescribed within 6 months prior to their enrollment date, to include pregnancy. See page 2 for additional information regarding this pre-existing condition exclusion.
48. **Private Duty Nursing** Charges in connection with care, treatment or services of a private duty nurse.
49. **Remicade Infusions**, if more frequent than every 8 weeks past the initial therapy.
50. **Replacement Braces** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is a sufficient change in the Covered Person's physical condition to make the original device no longer functional.
51. **Routine Examinations** or services in excess of any amounts specified by the Plan.
52. **Self-Inflicted Injury or Illness** Charges are excluded for intentionally self-inflicted Sickness or Injury unless it is a result of a medical condition (either physical or mental).
53. **Self Injectable Medication** given in the Doctor's Office.
54. **Service Covered by Other Insurance Policies** This Plan will pay only secondary to any other third party policy, to include, but not limited to, no fault or personal injury protection, catastrophic funds mandated by motor vehicle or other state law, uninsured motorist, motor vehicle medical reimbursement, (regardless whether it is purchased by the Plan member or Dependent), Homeowner's Insurance, Premises Policy, or any monies collected for pain and suffering.
55. **Services before or after coverage** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
56. **Sexual Dysfunctions** to include charges related to changing the sex of an individual, and any services for sexual dysfunctions or inadequacies, surgical insertion of a penile prosthesis including the cost of the prosthesis and complications thereof, regardless of diagnosis. Any prescription for this diagnosis is also excluded.

57. **Sleep Disorders** Care and treatment for sleep disorders unless deemed Medically Necessary.
58. **Smoking Cessation** Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically necessary due to a severe active lung Illness such as emphysema or asthma.
59. **Speech Therapy** (see definition of Speech Therapy).
60. **Surgical Sterilization Reversal** Care and treatment for reversal of surgical sterilization.
61. **Travel or accommodations** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.
62. **Telephone Charges** for telephone consultations.
63. **Temporomandibular Joint Syndrome** or any services provided to diagnosis or treat misalignment of the teeth or jaws.

64. **U. S. Government** Charges for services or supplies furnished by an agency of the federal, state, or local government, or a foreign government agency, unless required by law.
65. **Vision Care** Eye glasses or contact lenses or the fitting of either and all keratotomy procedures.
66. **Vision Therapy**
67. **Vocational Rehabilitation** by any name called.
68. **Weight Management** and the treatment thereof with the use of prescription drugs, surgery or other weight control programs.
69. **Work Related Injury or Illness**, which arises out of the course of any employment to include self-employment, ranching, farming, roofing, mechanics, etc.

DEFINED TERMS

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

Acute Care is a pattern of health care in which a patient is treated for an acute episode of Illness, for the sequelae of an accident or other trauma, or during recovery from surgery. Acute care is usually given in a Hospital by specialized personnel using complex and sophisticated technical equipment and materials, and it may involve intensive care or emergency care. This pattern of care is often necessary for only a short time, unlike chronic care.

Allowable Charge is based on both the In-Network fee schedule and the amounts accepted by other providers in the area for like treatment, care, services or supplies as established by the PPO Network, Ingenix and Benefit Management, Inc. BMI's determination of what is an allowable charge is final for the purpose of determining benefits payable under the Plan.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Baseline shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

Benefits mean the coverage your program provides. The benefits we provide for covered services are calculated starting with the billed charge or our allowed amount, whichever is less. We then subtract any deductible, co-payment and/or coinsurance amounts. These amounts are your share of the cost. The remaining portion of the charges are your benefits.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Breast Reduction Criteria

- 1) Must be Medically Necessary with documentation of pain in upper back, pain in neck, pain in shoulders, headaches or pain/ulceration from bra straps cutting into shoulders; and
- 2) Photographic Documentation of severe breast hypertrophy; and
- 3) At least 500 grams of breast tissue must be removed in order to be covered. Body Surface Area (BSA) criteria will be used to determine.

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

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

Co-insurance Maximum (also referred to as Out-of-Pocket Maximum) is the percent of charges not covered by the Plan that is the Participants responsibility.

Cosmetic Dentistry means dentally unnecessary procedures.

Cosmetic Treatment is a procedure directed at improving the patient's appearance which does not meaningfully promote the proper function of the body or prevent or treat illness or disease, unless the surgery is necessary to ameliorate a deformity arising from, or directly related to:

- A congenital abnormality;
- A personal injury resulting from an accident or trauma;
- A disfiguring disease. However, no payment shall be made for the surgical treatment of scarring secondary to acne or chicken pox to include, but not to be limited to, medication, dermabrasion, chemical peel, salabrasion and collagen injections.

Covered Charge is the actual charge for Medically Necessary and Appropriate treatment of Injury or Illness, not to exceed the Allowable Charge.

Covered Person is an Employee or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare.

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

Deductible is the dollar amount of eligible expenses that you are responsible for paying before you are eligible for benefits for most care. You must meet your deductible once each calendar year.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent

Any of the following persons:

- An Employee's spouse, unless legally separated or divorced;
- An Employee's unmarried children, from birth up to age 19, including natural children and legally adopted children stepchildren must reside in the Employee's home or be eligible due to a Qualified Medical Support Order issued to the Employee. However, a covered Dependent child will continue to be covered to age 25, provided the child is a full-time student as defined by the Plan;
- A covered unmarried Dependent child, regardless of age, who is mentally or physically handicapped, classified as disabled before the limiting age of 19 (25 if a full-time student) and dependent on the Employee for support and maintenance.

These persons are excluded as Dependents:

- The legally separated or divorced former spouse of the Employee;
- Any person who is on active duty in any military service or any country; or
- Any person who is eligible for coverage under the Plan as an Employee.

If husband and wife are both covered as Employees under the Plan, their children will be covered as Dependents of the husband or the wife, but not both.

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

Eligible Employee means a member of one of the following classes of Employees:

- (1) Active full-time Employees; or
- (2) Eligible retirees who qualify for benefits from either the Public School Retirement System of MO or the Non-Teacher School Employee Retirement System of MO; or
- (3) Part-time Employees regularly scheduled to work at least 30 hours per week, except student workers, substitute employees, or persons working in temporary positions.

Employer is Neosho R-5 School District.

Enrollment Date means the actual date of enrollment or, if earlier, the first day of the waiting period for enrollment (typically, the date of employment).

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

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

- (1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (4) If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical

trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

FMLA shall mean the Family and Medical Leave Act of 1993, as amended. FMLA Leave shall mean a leave of absence, which the Company is required to extend to an Employee under the provisions of the FMLA.

Full-Time Student is one who is attending classes at an accredited college, university or technical school with a regular teaching staff, curriculum, and student body. Attendance must be full-time. Full-time is considered to be the number of credits or courses required for full-time students as determined by the school.

Generic Drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

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

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

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

Hospice Agency is an organization where its main function is to provide hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

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

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.'s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes pregnancy, childbirth, miscarriage or complications of pregnancy.

Injury means an accidental physical injury to the body caused by unexpected external means.

Inpatient Treatment in an approved facility during the period when charges are made for room and board or the length of stay exceeds 23 hours.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a “coronary care unit” or an “acute care unit.” It has: facilities for special nursing care not available in regular rooms and wards of the hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

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

Lifetime is a work that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Necessity (Medically Necessary) is only those services, treatments, or supplies provided by a Hospital, a Doctor, or other qualified Provider of medical services or supplies that are required to treat an Injury or Sickness and which:

- a) are consistent with the symptoms and treatment of the individual’s condition, disease, ailment, or injury;
- b) are appropriate according to standards of good medical practice;
- c) represents the most appropriate level of care: the frequency of services, the duration of services, and the site of services (Hospital or Physician’s office);
- d) are not solely for the convenience of the individual, Doctor or Hospital;
- e) are not Experimental or Investigative.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean it will be covered by the Plan as Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

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

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International

Classification of Diseases, published by the US. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

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

Multiple Surgical Procedure The appropriateness of a bill for multiple surgical procedures must be clearly documented before a payment allowance is determined. The allowance for documented multiple surgical procedures, whether related or not, is 100% of the prevailing fee for the greater procedure and 50% of Allowable/UCR will be allowed for each secondary surgical procedure.

Exceptions to the Multiple Procedure Rule: The following lists situations where exceptions to the multiple procedure rule would be appropriate.

- d) Fractures: When reduction (or treatment) of one or more separate and distinct fractures takes place (such as an arm or leg), 100% of the prevailing fee is allowable for each fracture; and
- e) More than one Surgeon: When the skills of two or more Physicians are required and each surgeon performs a separate operation (e.g., a procedure is performed by a thoracic surgeon and fracture care is provided by an orthopedic surgeon), the allowance is 100% of the prevailing fee for each procedure, provided each of the doctors bills separately for the procedure he performed. This applies even though both procedures were performed at the same operative session.

This is a partial guideline. The complete guideline as established by Trilogy and Benefit Management, Inc. will be taken into account when determining benefits.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Office Visit means the evaluation and management of a new or established patient to acquire past medical history, examination and medical decision making for treatment of sickness or injury. Laboratory, X-ray or surgical procedures are not included.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

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

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

Sickness is:

For a covered Employee and covered Spouse: Illness, disease or Pregnancy.

For a covered Dependent other than Spouse: Illness or disease, not including Pregnancy or its complications.

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

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided;
- (2) Its services are provided for compensation and under the full-time supervision of a Physician;
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse;
- (4) It maintains a complete medical record on each patient;
- (5) It has an effective utilization review plan;

- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care or care of Mental Disorders;
- (7) It is approved and licensed by Medicare; and
- (8) Must meet the criteria of Skilled Care as determined by Benefit Management, Inc.

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

Speech Therapy by a licensed speech therapist. Therapy must be ordered by a Physician and follow either; (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a Covered Person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder. For example, cerebral vascular accident (stroke), cerebral tumor, or laryngectomy. Speech therapy for speech delay is excluded by the Plan.

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

Standard of Care is how similarly qualified practitioners in the same geographic area would have managed the patient's care under the same or similar circumstances.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means: In the case of a Dependent Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Usual and Reasonable Charge pertains to the amount that the Health Plan will recognize for payment. Benefit Management, Inc. will take into consideration amounts charged by Health Care providers for similar services and supplies when provided in the same general area. Benefit Management, Inc. will also consider provider cost of goods. Usual and Reasonable is not to be interpreted as the Fee Schedule or PPO Allowable. Usual and Reasonable limits may be applied to the In-

Network or PPO Providers. Benefit Management, Inc. has the discretionary authority to decide whether a charge is Usual and Reasonable.

ADMINISTRATION

PLAN ENROLLMENT AND MEMBERSHIP

Eligibility for Plan Membership

An individual is eligible for coverage under the Plan if that individual is a regular full-time or part-time active Employee scheduled to work at least 30 hours a week on a regular basis, or eligible retiree as defined under Chapter 169 RSMo.

Coat-tail Coverage

To be eligible for coverage as a spouse, you must provide proof that no health benefits are available through the spouse's employer.

Eligible Classes of Dependents

A Dependent is any one of the following persons:

- (1) A covered Employee's Spouse and unmarried children from birth to the limiting age of 25 years. All eligible Dependents must provide **acceptable** evidence of good health. The Dependent children must be primarily dependent upon the covered Employee for support and maintenance. When a child reaches the limiting age, coverage will end on the last day of the child's birthday month.
- (2) The term "children" shall include natural children living in the same household as the Employee, adopted children or children placed with a covered Employee in anticipation of adoption. Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household.

If a covered Employee is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase "primarily dependent upon" shall mean dependent upon the covered Employee for support and maintenance as defined by the Internal Revenue Code and the covered Employee must declare the child as an income tax deduction. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

Dependent children are eligible for coverage, to age 19, as long as they live in the Employee's home, are single and primarily dependent on the Employee for support. If the children do not live in the home, but the Employee is required to provide coverage due to a Qualified Medical Support Order, they are also eligible. Full time students under the age of 25 are also eligible Dependents, if they are primarily dependent on the Employee for support. The students must be enrolled in at least 12 college credit hours, or full-time in a technical school.

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

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

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

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

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

New Members First Enrollment Period

An individual must furnish evidence of insurability and complete an enrollment application form, furnished by the employer within 31 days from the date they are eligible for coverage. Once the application is received and if approved, coverage will be effective the first day of the month following approval. All eligible Dependents must enroll in order to be considered for coverage to be active .

Late Enrollment

Employees who apply for coverage after their initial 31-day eligibility period, must furnish acceptable evidence of insurability (a health statement) before coverage will be approved. Dependents applying for coverage at any time must furnish this information. Once approved, coverage will be effective on the first of the month following approval.

If an Employee is not actively at work on the day coverage would otherwise begin, then coverage will begin on the day the Employee begins active work. If a Dependent (other than a newborn child) is confined as an Inpatient to any medical facility on the day coverage would otherwise begin, then coverage will begin on the day after the Dependent is discharged.

Under no circumstance will coverage for a Dependent become effective prior to an Employee's coverage.

Newly Acquired Children

If a newly acquired child becomes an eligible Dependent, (and the Employee is currently enrolled) they may enroll during the 31 days beginning on the date of birth, adoption or placement for adoption. An application for enrollment is required.

QMCSO Provision

This Plan will provide Benefits to the child(ren) of a participant if a Qualified Medical Child Support Order (QMCSO) is issued regardless of whether the child(ren) reside with the participant. If a QMCSO is issued, then the child(ren) shall become alternate recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other participant. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

Procedural QMCSO Requirements. Within a reasonable period of time following receipt of a medical child support order, the Plan Administrator will notify the participant and each child specified in the order whether the order is or is not a Qualified Medical Child Support Order. A QMCSO is an order which creates or recognizes the right of an alternate recipient (participant's child who is recognized under the order as having a right to be enrolled under this Plan) or assigns to the alternate recipient the right to receive benefits. To be considered a Qualified Medical Child Support Order, the medical child support order must contain the following information:

- The name and last known mailing address of the participant and the name and address of each child to be covered by this Plan; and
- A reasonable description of the type of coverage to be provided by this Plan to each named child, or the manner in which the type of coverage is to be determined; and
- The period to which such order applies.

If the order is determined to be a Qualified Medical Child Support Order, each named child will be covered by this Plan in the same manner as any other Dependent child is covered by this Plan.

Coverage for a child under a QMCSO will begin on the latest of the following dates:

- (5) If the Employee already has coverage in force, the child will be covered as of the date the QMCSO is received; or
- (6) If the Employee already has coverage in force, the child will be covered as of the date specified by the QMCSO; or
- (7) If the Employee is within the waiting period as specified under the section entitled "Effective Date" the child will become effective the same date the Employee's coverage is effective; or
- (8) If the Employee is otherwise eligible but previously waived coverage, the Employee's and the child's coverage will become effective as of the date specified in (a) or (b) above.

Each named child will be considered a participant under this Plan but may designate another person, such as a custodial parent or legal guardian, to receive copies of explanations of benefits, checks and other material which would otherwise be sent directly to the named child.

If it is determined that the order is not a Qualified Medical Child Support Order, each named child may appeal that decision by submitting a written letter of appeal to the Plan Administrator. The Plan Administrator shall review the appeal and reply in writing within thirty (30) days of receipt of the appeal.

This Plan will not provide any type or form of benefit, or any option, not otherwise provided under this Plan, and all other Dependent eligibility, effective date and termination provisions will apply.

Premiums & Employee Contributions

Dependent coverage requires a contribution by the Employee. Premium contributions must be paid regardless of whether the Employee has earnings for that pay period. Premiums for persons, COBRA or retirees, and Employees on unpaid leave of absence or other leave are solely the responsibility of the covered person(s) and are due to the Plan on the first of the month for which coverage is to be provided.

Reinstatement of Coverage

If the coverage of an Employee and/or Dependent ends because the Employee has requested termination of such coverage or has requested cancellation of the payroll deduction, coverage for the Employee and/or any Eligible Dependents will be reinstated for coverage subject to the following conditions:

- (1) Each Employee and Eligible Dependent to be reinstated must submit a new enrollment form and a health statement of a form acceptable to the Plan.
- (2) Coverage will be reinstated on the first of the month following approval of the application for reinstatement based on the underwriting review, provided that all contributions due for coverage have been made on behalf of the Employee to be reinstated; however, all reinstated Participants will be subject to satisfaction of new deductible, co-insurance, and the Pre-existing Condition Limitations.

TERMINATION OF COVERAGE

Termination of Plan Membership

A plan member's coverage shall terminate at 12:01 a.m. on the day following the last day of employment. If a Plan member fails to qualify as an eligible Employee or Dependent due to a reduction of work hours, death of the Employee or voluntary termination of coverage, Employee and Dependent coverage terminates at the end of the month.

If coverage terminates because of one of the reasons outlined in this paragraph, the Plan member may continue coverage and that of his/her eligible Dependents for a limited time. Coverage under this Plan will terminate at 12:00 midnight on the last

day of the month, on whichever of the following events occurs first.

- Thirty (30) days following the date that any contribution required by the Plan member or a qualified beneficiary is due and unpaid; coverage is terminated on the paid-to-date;
- The date the Plan is terminated;
- The date the Plan member enters the armed forces on active duty; or
- A Plan member may elect to terminate coverage on an annual basis. Written notification must be received 30 days prior to the end of the Plan year.

COBRA Rights - Continuation of Coverage

If an Employee or Dependent would lose coverage under the Plan as a result of one of the following, the individual losing coverage may elect to continue their coverage under the provisions of COBRA.

The COBRA qualifying events are:

- (1) The death of an Employee;
- (2) The Employee's termination of employment (for reasons other than gross misconduct) or retirement;
- (3) A reduction in the Employee's hours of employment below 30 hours per week on a regular basis;
- (4) The Employee's entitlement to Medicare;
- (5) A divorce or legal separation from an Employee; and
- (6) A child's ceasing to be eligible under the terms of the Plan.

It is the obligation of the Employee to notify the employer within 60 days of any divorce, legal separation or child's ceasing to be eligible under the Plan. It is also the responsibility of the Employee to notify the Plan Administrator of any changes in marital status or address. If notice is not received within 60 days of a qualifying event, the provisions of COBRA do not apply.

Maximum Coverage Periods. If the Employee does choose continuation coverage, the employer is required to give the Employee coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated Employees or family members. The law requires that the Employee be afforded the opportunity to maintain continuation coverage for a period of 18 months. This 18 months may be extended to 36 months if other events (such as death, divorce, legal separation, or Medicare entitlement) occur during that 18 month period. For qualifying Employees who retire after age 62, Employee-only coverage may be extended for up to 36 months.

Multiple Qualifying Events: If COBRA coverage is elected following an Employee's termination of employment or reduction in work hours, and then another qualifying event occurs during the 18 month continuation period, that Employee's Dependents may continue their coverage for up to 36 months, rather than 18 by adding an additional 18 months to the original month period.

Social Security Disability: Special rules for disabled individuals may extend the maximum periods of coverage. If a qualified beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of a termination of employment or reduction in hours of employment and the qualified beneficiary properly notifies the Plan Administrator of the disability determination, the 18-month period is expanded to 29 months.

Disabled beneficiaries must notify the Plan Administrator of Social Security disability determinations. A notice must be provided within 60 days of a disability determination and prior to expiration of the 18-month period of COBRA coverage. These beneficiaries also must notify the Plan Administrator within 30 days of a final determination that they are no longer disabled.

Termination of COBRA Coverage: COBRA coverage for any individual will be automatically terminated upon the occurrence of any of the following events:

- (1) The premium for continuation coverage is not paid on time;
- (2) The COBRA member becomes covered by another group plan that contains no exclusion or limitation of benefits for any pre-existing condition or whose pre-existing condition limitation or exclusion does not apply to the member due to the requirements of the Health Insurance Portability and Accountability Act of 1996;
- (3) The COBRA member becomes entitled to Medicare; and
- (4) The employer no longer provides group health coverage to any of its Employees.

Coverage of Newborn or Newly Adopted Children: A child who is born to, adopted by or placed with a COBRA member is also eligible for coverage. That subsequent qualifying event provides the child with independent coverage eligibility up to 36 months beginning on the date of the Employee's original qualifying event.

Cost and Coverage: The monthly charge for COBRA coverage will be determined by the Plan Administrator, and cannot exceed 102% of the cost to the Plan for similarly situated individuals who have not incurred a qualifying event.

For disabled beneficiaries receiving an additional 11 months of coverage after the initial 18 months, the premium for those additional months may be increased to 150 percent of the Plan's total cost of coverage.

Premiums due may be increased if the cost to the Plan increases.

The initial premium payment must be made within 45 days after the date of the COBRA election by the qualified beneficiary. Payment generally must cover the period of coverage from the date of COBRA election retroactive to the date of the qualifying event. Premiums for successive periods of coverage are due on the date stated in the Plan with a minimum 30-day grace period for payments.

Specific Notices: A qualified beneficiary must notify the Plan Administrator within 60 days after events such as divorce or legal separation or a child's ceasing to be covered as a Dependent under plan rules. If notice is not received within 60 days of the qualifying event, the provisions of COBRA do not apply.

Uniformed Services Employment and Re-employment Rights Act

Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Re-employment Rights Act. These rights include up to 18 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage with no pre-existing condition exclusions applied in the Plan upon return from service. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

Plan exclusions and waiting periods may be imposed for any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

Continuation of Coverage Under FMLA

If you take a period of leave authorized by the Family and Medical Leave Act (FMLA Leave), you may continue coverage for yourself and your covered Dependents under the Plan during your period of FMLA Leave by making the same contributions you would have made had you continued your employment and participation in the Plan.

If you are entitled to a period of FMLA Leave or are on such Leave, and you inform your employer that you do not intend to return to active employment, you will have no right to continue coverage under the FMLA provisions. You may have a right to continue coverage under the COBRA provisions described above.

Payment for Coverage:

- (a) Paid Leave: If you are on a period of leave that is paid leave, your contributions will be made in the same manner that they would have been made had you continued your employment and participation in the Plan.
- (b) Unpaid FMLA Leave: If your FMLA Leave is unpaid, you must make your contributions no later than the time they would have been made had you not taken FMLA Leave but had instead continued your employment and participation in the Plan.
- (c) Termination of Coverage: If you are entitled to a period of FMLA Leave, you may elect not to continue your coverage. In that case, all coverage will terminate on the last day of the month for which you pay contributions. However, if you elect to continue coverage during a period of FMLA Leave, your Employee and Dependent coverage will continue until the earliest of:
 - (1) The date you fail to return to work for your employer after your period of FMLA Leave, after your employment is thereby terminated;
 - (2) The date you exhaust your entire FMLA Leave;
 - (3) The 30th day following the date your contribution was due and unpaid on the 30th day; or
 - (4) The date the Plan terminates.

Restoration of Coverage: If you are on FMLA Leave and do not continue or fail to pay for your coverage, you and your Dependents are entitled to reinstatement of coverage under the Plan upon your return from FMLA Leave.

Need to Repay Employer Contributions: If you began a period of FMLA Leave and continued coverage under this Plan, and you fail to return to work for at least 30 calendar days, your employer will have the right to recover the contributions made by the employer during your leave.

Exception to Repayment Rule: The employer will not have a right to recover its contributions if you fail to return from FMLA Leave due to a condition that would entitle you to a period of FMLA Leave or other circumstances beyond your control.

Special Rules for Key Employees: If you meet the definition of a Key Employee under the government regulations, special rules apply. If you are entitled to FMLA Leave and the employer informs you that it does not intend to restore you to your job at the end of

your leave because doing so would cause grievous economic injury to the employer's operations, and if you do not, within 30 days after receiving that notice, return to work for the employer, your coverage will continue until the earliest of:

- (a) The date you give notice to your employer that you no longer wish to return to work;
- (b) The date the employer denies your reinstatement to employment at the end of your FMLA Leave;
- (c) The 30th day following the date your contribution was due and unpaid on the 30th day; or
- (d) The date the Plan terminates.

Need to Repay Employer Contributions: This provision does not apply to key Employees and their Dependents if the employer denies employment reinstatement.

CLAIMS PROCESSING

Filing a Claim

All participants are required to submit at least one signed claim form each Plan year in order to receive benefits. All claims to be filed or inquiries regarding such claims should be directed to Benefit Management, Inc., P.O. Box 3001, Joplin, Missouri 64803. All claims must be received in the office of Benefit Management, Inc. within 6 months from the date of service to be eligible for coverage under the Plan.

All claims must be received within 90 days after the date of termination for all participants.

Appeal Procedure

If a claim dispute cannot be resolved with the claims office, a disputed claim review and appeal procedure can be requested.

First Appeal - The first review will begin by a request from the Plan member in writing. The request for a review must be submitted to the Plan within 60 days of the receipt of the claim offices benefit and payment determination. The request, addressed to the Claims Manager at Benefit Management, Inc., should include the patients name and the name of the covered Employee. Only the covered Plan member or Dependent can file an appeal. Please include all the reasons for requesting a review, stating as specifically as possible why it is believed the denial is incorrect. Any supplemental materials, including additional medical information, should also be submitted. Benefit Management, Inc.'s determination will be rendered as follows:

Urgent Claim - within 72 hours from receipt of the appeal. There can only be one level of appeal.

Pre-Service Claim - within 15 days from receipt of the appeal.

Post-Service Claim - within 30 days from receipt of the appeal.

The determination will be sent directly to the Plan member. The determination will reference the particular Plan provision(s) and facts upon which it is based.

Final Appeal - If the decision of Benefit Management, Inc. is unsatisfactory, a written request for a final appeal may be submitted by the Plan member to the office of the Plan Administrator or at the office of Benefit Management, Inc. The written request must be received within 180 days after the date of the adverse benefit decision. If there is any supplemental material, which has not been previously submitted, it must be submitted along with the notice of appeal. The Plan Administrator will render a determination as follows and any decision shall be considered final.

Pre-Service Claim - within 15 days from receipt of second appeal.

Post-Service Claim - within 30 days from receipt of second appeal.

COORDINATION OF BENEFITS & SUBROGATION

Coordination of Benefits (COB) means that the benefits provided by the Plan will be coordinated with the benefits provided by any other plans covering the person for whom a claim is made. If this plan is a secondary plan, the benefits payable under the plan may be reduced so that a covered person's total payment from all plans will not exceed 100% of the amount this Plan would have paid in the absence of the other Plan. Benefits payable under another plan include benefits that would have been payable had claim been duly made therefore. Benefits will not be coordinated within the Plan for Employees and Dependents who work for the company.

Order of Benefit Determination. For purposes of Coordination of Benefits, the rules establishing the order of benefit determination are as follows:

- (a) A plan that covers a person other than as a Dependent will be primary to a plan that covers such person as a Dependent.
- (b) A plan that covers a person as a Dependent of an Employee whose date of birth occurs earlier in a calendar year will be primary to a plan that covers such person as a Dependent of an Employee whose date of birth occurs later in a calendar year.
- (c) In the case of Dependent child(ren) whose parents are separated or divorced:
 - (1) When the parent with custody of the child has not remarried, the plan that covers the child as a Dependent of the parent with custody will be primary to the plan that covers the child as a Dependent of the parent without custody; and
 - (2) When the parent with custody of the child has remarried, the plan that covers the child as a Dependent of the parent with custody will be primary to the plan that covers the child as a stepparent, and the plan that covers the child as a Dependent of the stepparent will be primary to the plan that covers the child as a Dependent of the parent without custody.

Notwithstanding the above, if there is a court decree which establishes financial responsibility for the medical expenses of the child, the plan that covers the child as a Dependent of the parent with such responsibility will be primary to any other plan that covers the child as a Dependent.

When the rules stated above do not determine an order of benefit determination, the plan that has covered a person for the longer period of time will be primary, provided that the plan that covers the person as a laid-off or retired Employee, or as a Dependent of such an Employee will be secondary to any plan that covers such person as an active Employee or as a Dependent of such an Employee.

Payment to Other Organizations: Whenever payments that should have been made under this Plan in accordance with these coordination of benefits provisions have been made under any other plans, this Plan may pay to any entity making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of these provisions. Amounts so paid shall be deemed to be benefits paid under this Plan, and to the extent of such payments, this Plan shall be fully discharged from liability.

Reimbursement. If at any time the amount of benefits provided by this Plan exceed the maximum payment necessary to satisfy the intent of the coordination of benefits provisions, this Plan may recover any excess payments from any one or more of the following: (a) you; (b) if you are a Dependent, the Employee or retiree whose Dependent you are; (c) any other plan or person that has received payment; (d) any other plan that should have made payment.

Automobile Limitations. When medical payments are available under vehicle insurance, the Plan shall consider excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier. Benefits shall be considered under the provisions of COB, prior to the provisions of subrogation.

Limitation. Benefit payment for covered services will be reduced by benefits that could be paid by Part A and Part B of Medicare. This will apply even if a Covered person is eligible for Medicare but failed to enroll or maintain eligibility.

Third Party Liability. When medical payments are available under a third party liability, the Plan shall pay excess benefits only, without reimbursement for deductibles. This Plan shall always be considered the secondary carrier regardless of the Participants intent to pursue reimbursement from the third party. Benefits shall be considered under the provisions of COB prior to the provisions of subrogation.

Right to receive and release necessary information. In order to decide if this COB section (or any other Plan's COB section) applies to a claim, the Administrator (without the consent of or notice to any person) have the right to:

- a. Release to any person, insurance company or organization, the necessary claim information.
- b. Receive from any person, insurance company or organization, the necessary claim information.

Any person claiming Benefits under contract must give information needed to coordinate those Benefits.

Subrogation. It is the intent of the Plan to receive full recovery of all Benefits considered to you or for a Covered Person under this Plan on any loss for which a Third Party is liable, regardless of the date of service or the date of settlement. This should be understood to include the right to offset any and all future claims. Such recovery will be available from any liable Third Party, including but not limited to:

1. The persons and entities, either individually or collectively, causing an Injury, Illness or other loss for which the Plan had or may provide Benefits;
2. Third Party Insurance;
3. No-fault or Personal Injury Protection (“PIP”) insurance;
4. Financial responsibility or catastrophe funds mandated by motor vehicle or other state law;
5. Uninsured or motorist underinsured insurance;
6. Motor vehicle reimbursement insurance, regardless of whether or not is it purchased by you or the Dependents;
7. Homeowner’s insurance and other premises insurance, including reimbursement coverage.

This Plan is not intended to provide the member with benefits greater than his or her medical expenses. If the Plan member is entitled to payment of his or her medical expenses by another person, plan, or entity, whether they request payment or not, this Plan has the right to reduce its payments accordingly so that the Plan Member is not paid more than they actually owe for medical expenses. If the Plan Member has a right against any other person, firm, or organization for an Injury or Illness, or any complications thereof, the Plan has the right to subrogate all Benefits considered, or that will be considered, by the Plan because of the Illness or Injury or any other complications thereof. If the Plan considers benefits which are the responsibility or liability of a third party, the Plan has the right to recover any benefits paid.

Once the Plan Supervisor determines that third party liability may be involved with a claim, if applicable, the Plan Participant will be asked to sign a subrogation and reimbursement agreement, protecting the Plan against any loss where other parties may be responsible. The Plan Supervisor must have received the signed subrogation agreement before any claims may be considered for payment. If a signed subrogation agreement is not received within 90-days after being provided by the Plan Supervisor, the claims will be denied and the Plan will have no future responsibility for consideration of payment.

If the Covered Person, or the legal representative, fails to cooperate in fulfilling the responsibilities set forth in this section, no further benefits will be considered under this

Plan for charges incurred in connection with or resulting from the condition for which such loss is undergoing recovery proceedings.

The amount of this Plan's subrogation interest will be deducted first and in full from a Covered Person's recovery arising out of the Injury.

This Plan or the Plan Administrator, will not be required to pay attorney fees or other costs incurred in connection with its recovery unless it consents in writing to make such payment.

For purposes of this provision, any recovery from a third party paid to the Plan member by way of judgement, settlement, or otherwise to compensate for any losses, to include pain and suffering, will be deemed to be a recovery for medical, dental, vision and/or prescription drug expenses incurred to the extent of any actual loss due to Injury, Illness or Disability involved, to include any complications thereof.

Once settlement is reached, we will require copies of all court documents and/or settlement agreements. Benefits will then be adjudicated according to the rules of Coordination of Benefits.

ERISA RIGHTS

As a participant in some or all of the company's Employee benefit plans, the Plan member (or his/her beneficiary, spouse or legal representative) is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), which provides that Plan participants shall be entitled to do the following:

Examine, without charge, at the Plan Administrators Office and at other specified locations such as a work location, all Plan documents including insurance contracts and copies of all documents filed by the Plan with the U. S. Department of Labor and the Internal Revenue Service.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plans Annual Financial Report (Form 5500 or 5500-C). The Plan Administrator is required by law to furnish each Participant with a copy of this Annual Report.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the people who are responsible for the operation of any employee benefit plan.

The people who operate the Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of the Plan member and other Plan participants and

beneficiaries. No one, including the Plan members employer or any other person, may fire the Plan member or otherwise discriminate against the Plan member in any way to prevent the Plan member from exercising his/her rights under ERISA.

If the Plan members claim for benefits is denied in whole or in part, the Plan member must receive a written explanation of the reason for the denial. The Plan member has the right to have his/her claim reviewed and reconsidered.

Under ERISA, there are steps the Plan member can take to enforce the above rights. For instance, if the Plan member requests materials from the Plan Administrator and does not receive them within thirty (30) days, the Plan member may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Plan member up to \$100 a day until the Plan member receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan member has a claim for benefits, which denied or ignored in whole or in part, the Plan member may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plans money, or if the Plan member is discriminated against for asserting his/her rights, the Plan member may seek assistance from the U. S. Department of Labor, or the Plan member may file a suit in a federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the Plan member is discriminated against for asserting his/her rights, the Plan member may seek assistance from the U.S. Department of Labor, or the Plan member may file a suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan member is successful, the court may order the organization the Plan member has sued to pay these costs and fees. If the Plan member loses, the court may order the Plan member to pay these costs and fees (for example, if it finds that the claim is frivolous).

If the Plan member has any questions about the Plan, the Plan member should contact the Plan Administrator. If the Plan member has any questions about the Plan members rights under ERISA, the Plan member should contact the nearest area office of the U. S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. 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.

Any interpretation, determination of other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion.

Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described by this section.

Privacy

Your privacy is important to the Plan and Neosho R-5 School District. We have adopted a Privacy Policy, and will use our best efforts to ensure that your Private Health Information is protected. Our policy can be viewed or printed at the following website: www.gotobmi.com Click on the Privacy icon to access this policy.

Clerical Error

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

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.