

Group Health Benefit Plan

Medical Summary Plan Description

Effective January 1, 2007
Restated January 1, 2015

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INTRODUCTION

This document is a description of the City of Wichita Group Health Benefits Plan (the "Plan") for the exclusive benefit of and to provide health benefits to its Eligible Employees and their eligible Dependents and Retirees. No oral interpretations can change this Plan. The Plan described is designed to protect Members against certain catastrophic health expenses.

By carefully reading the Summary Plan Description (SPD) and understanding Your relationship to the Plan, You will be an informed Member. The participating Hospitals and physicians of the network have agreed to extend a discount to those employees and Covered Dependents that utilize their facilities. When Your claims for services are processed, You will see the amount of the discount on the Explanation of Benefits (EOB). This, of course, helps reduce Your liability for the cost of the services.

Additional Information has been provided at the end of this document. This information is not incorporated nor provided through the City of Wichita Group Health Benefits Plan. The Additional Information section is subject to change without notice or Amendment.

Notification of Grandfathered Status

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 268-4531. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

You Must Notify The Human Resources Department When One Of The Following Events Occur.

- Birth of child. (*within 60 days*).
 - Documentation from the Hospital is acceptable for initial enrollment. However, you are allowed 60 days from the date of birth to provide the certified birth certificate. If the certified birth certificate is not received in HR by then, coverage for any undocumented Dependents will be dropped retroactively.
- Marriage. (*within 60 days*).
 - State or the District Court-Certified Marriage License
- Adoption of child. (*within 60 days*).
 - State-issued birth certificate or adoption agreement
- Divorce. (*within 60 days*).
 - Court-ordered Divorce Decree – Final

You Must Be Sure That Your Providers Have The Current Billing Instructions Provided On Your Identification Card. Failure To Submit Claims Properly May Result In Delayed Claims Processing.

SCHEDULE OF BENEFITS: Premium Plan Option

The following section **Schedule of Benefits** provides the health care services and supplies covered under this Plan. The schedule is provided to assist You with determining the level of coverage and Pre-Certification procedures that apply for Covered Services when determined to be Medically Necessary, subject to the exclusions and limitations.

The PREMIUM PLAN OPTION as described in the Schedule of Benefits of the existing Summary Plan Description shall be considered the base plan for all Plan participants; provided, however, the Plan Sponsor hereby offers an optional, voluntary, elective second benefit option which is hereby incorporated into the Summary Plan Description as the SELECT PLAN OPTION. To participate in the SELECT PLAN OPTION, employees and Retirees must formally elect the SELECT PLAN OPTION by completing and submitting the appropriate SELECT PLAN OPTION enrollment forms. Benefits shall be provided under the voluntary PREMIUM PLAN OPTION as follows.

PREMIUM PLAN OPTION Covered Services	Cost to Member when Receiving Services from Participating Providers (In-Network)	Cost to Member when Receiving Services from Non-Participating Providers (Out-of-Network) ²
Annual Plan Deductible (does not include Copayments)	\$0 Individual / \$0 Family	\$200 Individual / \$400 Family
Coinsurance For All Eligible Expenses (unless otherwise noted)	0% Coinsurance	50% Coinsurance
Out-of-Pocket Maximum Includes Coinsurance only (not Deductibles, Copayments, or other out-of-pocket expenses)	None	\$1,000 Individual / \$2,000 Family
Benefit Maximum Medical Annual Lifetime Cochlear Implants & Services Lifetime	No Annual Maximum No Lifetime Maximum Limited to One Implant Per Ear; Per Lifetime	
Primary Care Physician (PCP) Services <ul style="list-style-type: none"> ▪ Physician Office Visit and Related Physician Services ▪ Physician Office Surgery ▪ Other Physician Services (unless noted elsewhere) ▪ Allergy Injections ▪ Allergy Testing 	\$20 Copayment \$20 Copayment \$0 Copayment \$0 Copayment \$20 Copayment	Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance
Specialty Physician Services <ul style="list-style-type: none"> ▪ Physician Office Visit and Related Physician Services ▪ Physician Office Surgery 	\$20 Copayment \$20 Copayment	Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance

PREMIUM PLAN OPTION Covered Services	Cost to Member when Receiving Services from Participating Providers (In-Network)	Cost to Member when Receiving Services from Non-Participating Providers (Out-of-Network) ²
<ul style="list-style-type: none"> ▪ Other Physician Services (unless noted elsewhere) ▪ Allergy Injections ▪ Allergy Testing 	<p style="text-align: center;">\$0 Copayment</p> <p style="text-align: center;">\$0 Copayment</p> <p style="text-align: center;">\$20 Copayment</p>	<p style="text-align: center;">Deductible Plus 50% Coinsurance</p> <p style="text-align: center;">Deductible Plus 50% Coinsurance</p> <p style="text-align: center;">Deductible Plus 50% Coinsurance</p>
<p>Preventive Care</p> <ul style="list-style-type: none"> ▪ Annual Well Woman Exam ▪ Mammograms (Diagnostic and Routine Screening) ▪ Well Baby and Child Care ▪ Annual Prostate Screening - High Risk or Symptomatic (Age 40+) and All Males (Age 50+) ▪ Routine Health Screening 	<p style="text-align: center;">\$20 Copayment</p> <p style="text-align: center;">\$0 Copayment</p> <p style="text-align: center;">\$20 Copayment</p> <p style="text-align: center;">\$20 Copayment</p> <p style="text-align: center;">\$20 Copayment (Effective January 1, 2016, copayment waived one time per Plan Year for Subscriber only)</p>	<p style="text-align: center;">Deductible Plus 50% Coinsurance</p>
<p>Immunizations</p> <ul style="list-style-type: none"> ▪ Pediatric (up to age 72 months) ▪ Adult 	<p style="text-align: center;">No Copayment</p> <p style="text-align: center;">No Copayment</p>	<p style="text-align: center;">No Copayment</p> <p style="text-align: center;">Deductible Plus 50% Coinsurance</p>
<p>Hospital Inpatient Services</p> <p>Services include semi-private Hospital room & board, physician and surgeon services, lab, x-ray and other facility and ancillary charges.</p>	<p style="text-align: center;">\$100 Copayment per Day</p> <p style="text-align: center;"><i>\$500 Inpatient Copayment limit per person per calendar year</i></p> <p style="text-align: center;"><i>\$1,000 Inpatient Copayment per family per calendar year</i></p>	<p style="text-align: center;">Deductible Plus 50% Coinsurance</p>
<p>Outpatient Laboratory Services</p>	<p style="text-align: center;">\$0 Copayment</p>	<p style="text-align: center;">Deductible Plus 50% Coinsurance</p>
<p>Hospital Outpatient Surgery and Scopes includes related Professional Charges</p>	<p style="text-align: center;">\$200 Copayment</p>	<p style="text-align: center;">Deductible Plus 50% Coinsurance</p>
<p>Outpatient Surgery and Scopes performed in an Ambulatory Surgery Center</p> <p>includes related Professional Charges</p>	<p style="text-align: center;">\$200 Copayment</p>	<p style="text-align: center;">Deductible Plus 50% Coinsurance</p>
<p>Outpatient X-rays</p> <p>includes related Professional Charges</p>	<p style="text-align: center;">\$0 Copayment</p>	<p style="text-align: center;">Deductible Plus 50% Coinsurance</p>
<p>Outpatient Diagnostic Testing and Services (Not Listed Elsewhere)</p> <ul style="list-style-type: none"> ▪ Performed in Hospital ▪ Performed in Other Outpatient Setting includes related Professional Charges 	<p style="text-align: center;">\$0 Copayment</p>	<p style="text-align: center;">Deductible Plus 50% Coinsurance</p>

PREMIUM PLAN OPTION Covered Services	Cost to Member when Receiving Services from Participating Providers (In-Network)	Cost to Member when Receiving Services from Non-Participating Providers (Out-of- Network) ²
Emergency Services <ul style="list-style-type: none"> Emergency Room Copayment waived if admitted Related Professional Fees 	\$100 Copayment for Facility Charges \$0 Copayment for Related Professional Fees	\$100 Copayment for Facility Charges \$0 Copayment for Related Professional Fees
Ambulance/Emergency Transportation (Ground or Air)	\$0 Copayment	\$0 Copayment
Urgent Care	\$20 Copayment	\$20 Copayment
Maternity Care <ul style="list-style-type: none"> Professional Services for Maternity Care & Delivery Other services (including Hospital services)	\$20 Copayment See Appropriate Benefits	Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance
Outpatient Short Term Therapy <ul style="list-style-type: none"> Physical Therapy Occupational Therapy Speech Therapy 	\$20 Copayment <i>Limited to 60 visits per Calendar Year Benefit Maximum</i>	Deductible Plus 50% Coinsurance
Rehabilitation <ul style="list-style-type: none"> Inpatient Partial Day Programs (4 hours or greater) Outpatient (Pulmonary, Cardiac) 	\$100 per Day Copayment up to a \$500 Maximum <i>\$500 Inpatient Copayment limit per person per calendar year</i> <i>\$1,000 Inpatient Copayment per family per calendar year</i> \$20 Copayment <i>Limited to 60 visits per Calendar Year Benefit Maximum</i> \$20 Copayment <i>Limited to 60 visits per Calendar Year Benefit Maximum</i>	Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance
Home Health Care	\$0 Copayment	Deductible Plus 50% Coinsurance
Skilled Nursing Facility	\$0 Copayment	Deductible Plus 50% Coinsurance
Hospice Care	\$0 Copayment	Deductible Plus 50% Coinsurance
Durable Medical Equipment	\$0 Copayment	Deductible Plus 50% Coinsurance
Prosthetics & Braces	\$0 Copayment	Deductible Plus 50% Coinsurance
Cochlear Implants and Services	See Appropriate Benefits <i>(Limited to one implant per ear; per Lifetime)</i>	Deductible Plus 50% Coinsurance
Chiropractic Services / Spinal Manipulation	\$20 Copayment <i>Limited to 26 visits per Calendar Year Benefit Maximum</i>	Not Covered
Organ Transplant	See Appropriate Benefits	Not Covered

PREMIUM PLAN OPTION Covered Services	Cost to Member when Receiving Services from Participating Providers (In-Network)	Cost to Member when Receiving Services from Non-Participating Providers (Out-of- Network) ²
Transportation, Lodging & Meals when related to Organ Transplants	\$0 Copayment <i>(Limited to \$2,000 per Calendar Year Benefit Maximum)</i>	Not Covered
Mental/Nervous Treatment Inpatient Limited to Semi-Private Rate	\$100 Copayment <i>\$500 Inpatient Copayment limit per person per calendar year \$1,000 Inpatient Copayment per family per calendar year Limited to 45 days per Calendar Year Benefit Maximum</i>	Deductible Plus 50% Coinsurance
Outpatient <i>First (2) visits covered at 100%.</i>	\$20 Copayment <i>Limited to 45 visits per Calendar Year Benefit Maximum</i>	Deductible Plus 50% Coinsurance
Substance Abuse & Chemical Dependency Treatment Inpatient Limited to Semi-Private Rate Outpatient <i>First (2) visits covered at 100%.</i>	\$100 Copayment <i>\$500 Inpatient Copayment limit per person per calendar year \$1,000 Inpatient Copayment per family per calendar year Limited to 30 days per Calendar Year Benefit Maximum</i> \$20 Copayment	Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance
Injectable Medications (Medically administered)	\$0 Copayment	Deductible Plus 50% Coinsurance
Outpatient Dialysis	\$0 Copayment	Deductible Plus 50% Coinsurance
Infertility	\$20 Copayment	Deductible Plus 50% Coinsurance
Formula & Low Protein Modified Foods for PKU & Amino Acid Disease	\$0 Copayment	Deductible Plus 50% Coinsurance
Human Leukocyte Antigen Testing	\$0 Copayment	Deductible Plus 50% Coinsurance
Nutritional Evaluation & Diabetes Management/Self-Training	\$0 Copayment	Deductible Plus 50% Coinsurance
Dental Services Accidental Injury Impacted Wisdom Teeth Intraoral X-Rays <i>When in connection with Covered oral surgery services</i> Myofascial Pain & Temporomandibular Joint (TMJ) Dysfunction Syndromes	\$0 Copayment <i>Limited \$1,000 per accident during a consecutive twelve (12) month period</i> Out of Network Deductible Plus 50% Coinsurance \$0 Copayment Out of Network Deductible Plus 50% Coinsurance	Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance

SCHEDULE OF BENEFITS: Select Plan Option

The following section **Schedule of Benefits** provides the health care services and supplies covered under this Plan. The schedule is provided to assist You with determining the level of coverage and Pre-Certification procedures that apply for Covered Services when determined to be Medically Necessary, subject to the exclusions and limitations.

The PREMIUM PLAN OPTION as described in the Schedule of Benefits of the existing Summary Plan Description shall be considered the base plan for all Plan participants; provided, however, the Plan Sponsor hereby offers an optional, voluntary, elective second benefit option which is hereby incorporated into the Summary Plan Description as the SELECT PLAN OPTION. To participate in the SELECT PLAN OPTION, employees and Retirees must formally elect the SELECT PLAN OPTION by completing and submitting the appropriate SELECT PLAN OPTION enrollment forms. Benefits shall be provided under the voluntary SELECT PLAN OPTION as follows.

Covered Services	Cost to Member when Receiving Services from Participating Providers (In-Network)	Cost to Member when Receiving Services from Non-Participating Providers (Out-of- Network)
Annual Plan Deductible (does not include Copayments)	\$500 Individual / \$1,000 Family	\$1,000 Individual / \$2,000 Family
Coinsurance For All Eligible Expenses (unless otherwise noted)	20% Coinsurance	50% Coinsurance
Out-of-Pocket Maximum Includes Deductible and Coinsurance (not Copayments or other out-of-pocket expenses)	\$2,500 Individual / \$5,000 Family	\$5,000 Individual / \$10,000 Family
Benefit Maximum Medical Annual Lifetime Cochlear Implants & Services Lifetime	No Annual Maximum No Lifetime Limit Limited to One Implant Per Ear; Per Lifetime	
Primary Care Physician (PCP) Services <ul style="list-style-type: none"> ▪ Physician Office Visit and Related Physician Services ▪ Other Physician Services (unless noted elsewhere) ▪ Allergy Injections ▪ Allergy Testing 	\$25 Copayment \$25 Copayment \$0 Copayment \$25 Copayment	Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance
Specialty Physician Services <ul style="list-style-type: none"> ▪ Physician Office Visit and Related Physician Services ▪ Physician Office Surgery ▪ Allergy Injections ▪ Allergy Testing 	\$50 Copayment \$50 Copayment \$0 Copayment \$50 Copayment	Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance

Covered Services	Cost to Member when Receiving Services from Participating Providers (In-Network)	Cost to Member when Receiving Services from Non-Participating Providers (Out-of- Network)
Preventive Care <ul style="list-style-type: none"> ▪ Annual Well Woman Exam ▪ Mammograms (Diagnostic and Routine Screening) ▪ Well Baby and Child Care ▪ Annual Prostate Screening - High Risk or Symptomatic (Age 40+) and All Males (Age 50+) ▪ Routine Health Screening 	<p style="text-align: center;">Same as Office Visit \$0 Copayment</p> <p style="text-align: center;">Same as Office Visit Same as Office Visit</p> <p style="text-align: center;">Same as Office Visit (Effective January 1, 2016, copayment waived one time per Plan Year for Subscriber only)</p>	<p style="text-align: center;">Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance</p> <p style="text-align: center;">Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance</p> <p style="text-align: center;">Deductible Plus 50% Coinsurance</p>
Immunizations <ul style="list-style-type: none"> ▪ Pediatric (up to age 72 months) ▪ Adult 	<p style="text-align: center;">\$0 Copayment</p> <p style="text-align: center;">\$0 Copayment</p>	<p style="text-align: center;">\$0 Copayment</p> <p style="text-align: center;">Deductible Plus 50% Coinsurance</p>
Hospital Inpatient Services Services include semi-private Hospital room & board, physician and surgeon services, lab, x-ray and other facility and ancillary charges.	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
Outpatient Laboratory Services	\$0 Copayment	Deductible Plus 50% Coinsurance
Hospital Outpatient Surgery and Scopes includes related Professional Charges	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
Outpatient Surgery and Scopes performed in an Ambulatory Surgery Center includes related Professional Charges	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
Outpatient X-rays includes related Professional Charges	\$0 Copayment	Deductible Plus 50% Coinsurance
Outpatient Diagnostic Testing and Services (Not Listed Elsewhere) <ul style="list-style-type: none"> ▪ Performed in Hospital ▪ Performed in Other Outpatient Setting includes related Professional Charges 	\$0 Copayment	Deductible Plus 50% Coinsurance
Emergency Services <ul style="list-style-type: none"> ▪ Emergency Room (Copayment waived if admitted) ▪ Related Professional Fees 	<p style="text-align: center;">\$150 Copayment for Facility Charges</p> <p style="text-align: center;">\$0 Copayment for Related Professional Fees</p>	<p style="text-align: center;">\$150 Copayment for Facility Charges</p> <p style="text-align: center;">\$0 Copayment for Related Professional Fees</p>
Ambulance/Emergency Transportation (Ground or Air)	\$0 Copayment	\$0 Copayment
Urgent Care	\$50 Copayment	\$50 Copayment
Maternity Care		

Covered Services	Cost to Member when Receiving Services from Participating Providers (In-Network)	Cost to Member when Receiving Services from Non-Participating Providers (Out-of- Network)
<ul style="list-style-type: none"> ▪ Professional Services for Maternity Care & Delivery ▪ Other services (including Hospital services) 	\$50 Copayment See Appropriate Benefits	Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance
Outpatient Short Term Therapy <ul style="list-style-type: none"> ▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy 	\$50 Copayment <i>Limited to 60 visits per Calendar Year Benefit Maximum</i>	Deductible Plus 50% Coinsurance
Rehabilitation <ul style="list-style-type: none"> ▪ Inpatient ▪ Partial Day Programs (4 hours or greater) ▪ Outpatient (Pulmonary, Cardiac) 	Deductible Plus 20% Coinsurance Deductible Plus 20% Coinsurance <i>Limited to 60 visits per Calendar Year Benefit Maximum</i> Deductible Plus 20% Coinsurance <i>Limited to 60 visits per Calendar Year Benefit Maximum</i>	Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance
Home Health Care	\$0 Copayment	Deductible Plus 50% Coinsurance
Skilled Nursing Facility	\$0 Copayment	Deductible Plus 50% Coinsurance
Hospice Care	\$0 Copayment	Deductible Plus 50% Coinsurance
Durable Medical Equipment	\$0 Copayment	Deductible Plus 50% Coinsurance
Prosthetics & Braces	\$0 Copayment	Deductible Plus 50% Coinsurance
Cochlear Implants and Services	See Appropriate Benefits <i>Limited to one implant per ear; per Lifetime</i>	Deductible Plus 50% Coinsurance
Chiropractic Services / Spinal Manipulation	\$25 Copayment <i>Limited to 26 visits per Calendar Year Benefit Maximum</i>	Not Covered
Organ Transplant	See Appropriate Benefits	Not Covered
Transportation, Lodging & Meals when related to Organ Transplants	\$0 Copayment <i>(Limited to \$2,000 per Calendar Year Benefit Maximum)</i>	Not Covered
Mental/Nervous Treatment Inpatient - Limited to Semi-Private Rate Outpatient <i>First (2) visits covered at 100%.</i>	Deductible Plus 20% Coinsurance <i>Limited to 45 days per Calendar Year Benefit Maximum</i> \$50 Copayment <i>Limited to 45 visits per Calendar Year Benefit Maximum</i>	Deductible Plus 50% Coinsurance Deductible Plus 50% Coinsurance
Substance Abuse & Chemical Dependency Treatment Inpatient - Limited to Semi-Private Rate	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance

Covered Services	Cost to Member when Receiving Services from Participating Providers (In-Network)	Cost to Member when Receiving Services from Non-Participating Providers (Out-of- Network)
	<i>Limited to 30 days per Calendar Year Benefit Maximum</i>	
Outpatient <i>First (2) visits covered at 100%.</i>	\$50 Copayment	Deductible Plus 50% Coinsurance
Injectable Medications (Not listed elsewhere)	\$0 Copayment	Deductible plus 50% Coinsurance
Outpatient Dialysis	\$0 Copayment	Deductible Plus 50% Coinsurance
Infertility includes diagnosis and diagnostic surgical treatment only	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
Formula & Low Protein Modified Foods for PKU & Amino Acid Disease	\$0 Copayment	Deductible Plus 50% Coinsurance
Human Leukocyte Antigen Testing	\$0 Copayment	Deductible Plus 50% Coinsurance
Nutritional Evaluation & Diabetes Management/Self-Training	\$0 Copayment	Deductible Plus 50% Coinsurance
Dental Services Accidental Injury	\$0 Copayment	Deductible Plus 50% Coinsurance
Impacted Wisdom Teeth	Out of Network Deductible Plus 50% Coinsurance	Deductible Plus 50% Coinsurance
Intraoral X-Rays <i>When in connection with Covered oral surgery services</i>	\$0 Copayment	Deductible Plus 50% Coinsurance
Myofascial Pain & Temporomandibular Joint (TMJ) Dysfunction Syndromes	Out of Network Deductible Plus 50% Coinsurance	Deductible Plus 50% Coinsurance

* Primary Care Physicians (PCP) generally include those physicians who practice in the specialties of Family Practice, Internal Medicine, General Practice, or Pediatrics. If you are not sure if a physician is a PCP, please contact the Customer Service Number on the back of your ID card. If you receive this service from a Primary Care Physician (PCP), your PCP payment will apply. If you receive these services from a Specialist, your Specialist payment will apply.

DEFINITIONS

“Activities of Daily Living”

Activities you usually do during a normal day including but not limited to bathing, dressing, eating, maintaining continence, toileting, transferring from bed to chair, and mobility.

“Adverse Benefit Determination”

A denial of a request for service or a failure to provide or make payment in whole or in part for a benefit. An Adverse Benefit Determination may be based in whole or in part on a medical judgment and may also include:

- Any reduction or termination of a benefit;
- The failure to cover services because they are determined to be Experimental or Investigational;
- The failure to cover services because they are determined to not be Medically Necessary or medically appropriate;
- The failure to cover services because they are cosmetic;
- The failure, reduction, or termination regarding the availability and/or delivery of health care services;
- The failure, reduction, or termination regarding claims payment, handling or reimbursement for health care services; and/or
- The failure, reduction, or termination regarding terms of the contractual relationship between Member and the Plan.

“Alternate Facility”

A duly-licensed non-Hospital health care facility or an attached facility designated as such by a Hospital which provides one or more of the following services on an outpatient basis pursuant to the law of the jurisdiction in which treatment is received, including without limitation:

- Scheduled surgical services;
- Emergency Services;
- Urgent Care Services;
- Prescheduled rehabilitative services;
- Laboratory or diagnostic services;
- Inpatient or outpatient Mental Illness services or Substance Abuse services.

“Alternate Recipient”

The child or children identified in the medical child support order as being eligible to receive health care Coverage pursuant to the medical child support order.

“Amendment”

Any attached written description of additional or alternative provisions to the Agreement and/or this SPD. Amendments are effective only when Authorized in writing by the Plan and are subject to all conditions, limitations and exclusions of the Agreement except for those which are specifically amended.

“Ancillary Provider”

A Provider who is not licensed as a Physician or a Hospital.

“Appeal”

An Appeal is a request by You or Your Authorized Representative for consideration of an Adverse Benefit Determination of a service request or benefit that You believe You are entitled to receive.

“ASP”

Administrative Services Provider (Coventry Health Care of Kansas, Inc.)

“Authorized Representative”

An Authorized Representative is an individual authorized in writing or verbally by You or by state law to act on Your behalf in requesting a health care service, obtaining claim payment or during the Appeal process. A Provider may act on Your behalf with Your expressed consent, or without Your expressed consent when it involves an Urgent Care claim or Appeal. An Authorized Representative does not constitute designation of a personal representative for Health Insurance Portability and Accountability Act (“HIPAA”) privacy purposes.

“Calendar Year”

The period of time from January 1 through December 31 inclusive. This is the period during which the total amount of annual benefits under Your Coverage is calculated.

“Calendar Year Benefit Maximum”

A maximum dollar amount, or maximum number of days, visits or sessions for which Covered Services are provided for a Member in any one Calendar Year. Once a Calendar Year Benefit Maximum is met, no more Covered Services will be provided during the same Calendar Year.

“Chemical Dependency”

The psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

“Chiropractic Services”

Services provided by a duly-licensed Doctor of Chiropractic Medicine, including but not limited to subluxation and manipulation.

“City”

The City of Wichita, Kansas

“COBRA”

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

“Coinsurance”

Cost-sharing arrangement in which the Member pays a specified percentage of the cost for a Covered Service.

“Community Mental Health Center”

A legal entity certified by the department of mental health or accredited by a nationally recognized organization, through which a comprehensive array of mental health services are provided to individuals.

“Complaint”

Any dissatisfaction expressed by You or Your Authorized Representative regarding a Plan issue.

“Confinement” and “Confined”

An uninterrupted stay following formal admission to a Hospital, an Alternate Facility or Skilled Nursing Facility.

“Copayment”

Cost-sharing arrangement in which a Member pays a specified dollar amount as their share of the cost for a Covered Service.

“Cosmetic Services and Surgery”

Services performed to reshape structures of the body in order to alter appearance, to alter the aging process, or when performed primarily for psychological purposes. Cosmetic Services are not needed to correct or substantially improve a bodily function.

“Coverage” or “Covered”

The entitlement by a Member to Covered Services under the SPD, subject to the terms, conditions, limitations and exclusions of the SPD, including the following conditions: (a) services must be provided when the SPD is in effect; and (b) services must be provided prior to the date that any of the termination conditions listed in this SPD occur; and (c) services must be provided only when the recipient is a Member and meets all eligibility requirements specified in the SPD; and (d) services must be Medically Necessary.

“Covered Services”

The services or supplies provided to You for which the Plan will make payment, as described in the Agreement.

“Custodial Care”

Care is considered custodial when it is primarily for the purpose of helping the Member with Activities of Daily Living or meeting personal needs and can be provided safely and reasonably by people without professional skills or training. This term includes such other care that is provided to a Member who, in the opinion of the Medical Director, has reached his or her maximum level of recovery. This term also includes services to an institutionalized Member, who cannot reasonably be expected to live outside of an institution. Examples of Custodial Care include, but are not limited to, respite care and home care which is or which could be provided by family members or private duty caregivers.

“Customer Service”

Coventry Health Care of Kansas customer service established for the purpose of communication with the Members of the Health Plan.

“Day Program Services”

A structured, intensive day or evening treatment or partial hospitalization program, certified or accredited by a nationally recognized organization.

“Deductible”

The dollar amount of medical expenses for Covered Services that You are responsible for paying annually before benefits subject to the Deductible are payable under this Agreement.

“Dental Services”

Services primarily for the prevention, Diagnosis and treatment of diseases and injuries to the oral cavity, the teeth, and their surrounding structures.

“Dependent”

Any member of a Subscriber’s family who meets the eligibility requirements and who is properly enrolled for Coverage under the Agreement and on whose behalf premiums are paid by You or the City.

“Diagnosis”

The classification of a recognized physical or mental illness, or Chemical Dependency through clinical assessment or laboratory examination.

“Durable Medical Equipment”

Medical equipment Covered under this SPD or attached Rider, which can withstand repeated use and is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of an Illness or Injury, and is appropriate for use in the home. Medically Necessary, non-disposable accessories that are commonly associated with the use of a Covered piece of Durable Medical Equipment will be considered Durable Medical Equipment.

“Effective Date”

The date of Coverage as determined by the City and the Plan.

“Elective Abortion”

An abortion for any reason other than a spontaneous abortion or to prevent the death of the Member upon whom the abortion is performed.

“Eligible Employee”

An individual employed by the City who meets all the eligibility requirements specified in this SPD.

“Eligible Expenses”

Charges for Covered Services, incurred while the coverage is in effect.

“Emergency Medical Condition” and “Medical Emergency”

The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but shall not be limited to:

- Placing the Member’s health in significant jeopardy;
- Serious impairment to a bodily function;
- Serious dysfunction of any bodily organ or part;
- Inadequately controlled pain; or
- With respect to a pregnant woman who is having contractions:
 - That there is inadequate time to effect a safe transfer to another Hospital before delivery; or
 - That the transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

Some examples of an Emergency Medical Condition include, but are not limited to:

- Broken bone;
- Chest pain;
- Seizures or convulsions;

- Severe or unusual bleeding;
- Severe burns;
- Suspected poisoning;
- Trouble breathing;
- Vaginal bleeding during pregnancy.

The Member may seek medical attention from a Hospital, Physician's office or some other Emergency facility.

“Emergency Services”

Generally, Eligible Expenses for Emergency Services are the charges for the services provided during the course of the Medical Emergency, and when Medically Necessary for stabilization and initiation of treatment. The Emergency Services must be provided by or under the direction of a Physician, and are subject to the exclusions and other provisions set out in this SPD.

“Employee Enrollment/Change Form”

Your application for enrollment in the Plan.

“Experimental or Investigational”

A health product or service is deemed Experimental or Investigational if one or more of the following conditions are met:

- Any drug not approved for use by the Federal Food and Drug Administration (“FDA”); any drug that is classified as an Investigational New Drug (“IND”) by the FDA; any drug that is proposed for off-label prescribing. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA. Off-label prescribing for the treatment of cancer is not considered Experimental or Investigational.
- Any health product or service that is subject to Institutional Review Board (IRB) review or approval.
- Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations, except as specifically covered.
- Any health product or service whose effectiveness is unproven or is not considered standard treatment by the medical community, based on clinical evidence reported by Peer-Reviewed Medical Literature and by generally recognized academic experts.

“FDA”

Federal Food and Drug Administration.

“Home Health Care Agency”

An organization that meets all of these tests: (a) its main function is to provide Home Health Care Services and supplies; (b) it is federally certified by Medicare as a home health care agency; and (c) it is licensed by the state in which it is located, if licensing is required.

“Home Health Care Services”

Skilled nursing care and intermittent home health aide services provided in your home through a home health care agency, including physical therapy, speech therapy, occupational therapy, and medical supplies for the treatment of an illness or injury.

“Hospital”

An institution, operated pursuant to law, which: (a) is primarily engaged in providing services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of one or more Physicians; and (b) has twenty-four (24) hour nursing services on duty or on call. For the purpose of this definition, a facility that is primarily a place for rest, Custodial Care or care of the aged, a nursing home, convalescent home, or similar institution is not a Hospital.

“Illness”

Physical ailment, disease, or pregnancy. For the purpose of this definition, the term Illness does not apply to Mental Illness or Substance Abuse.

“Infertility”

Any medical condition causing the inability or diminished ability to reproduce.

“Infertility Services”

Those services including Confinement, treatment or services related to the restoration of fertility or the promotion of conception.

“Injury”

Bodily damage, other than Illness, including all related conditions and recurrent symptoms.

“Inquiry”

Any question from You or Your Authorized Representative that is not a Pre-Service Appeal, a Post-Service Appeal or an Urgent Care Appeal, or Complaint.

“Institutional Review Board (“IRB”)”

A panel formed pursuant to Part 46 of Title 45 of the United States Code of Federal Regulations that review, monitors, and approves research activities for which a federal department or agency has specific responsibility for regulating as a research activity (for example, investigational new drug requirements administered by the U.S. Food and Drug Administration).

“Late Enrollees”

Shall mean individuals who fail to enroll with the Plan for Coverage under the Agreement during the initial enrollment period when they first become eligible for Coverage as described in the Enrollment and Eligibility Section of this SPD. This term does not include individuals who enroll under a Special Enrollment Period; an employee of an employer which offers multiple health benefit plans, who elects a different health benefit plan during an Open Enrollment Period; or a Spouse or minor child who is eligible for Coverage due to a court order.

“Lifetime”

Lifetime refers to the life of the Member without regard to health insurance carrier.

“Limiting Age”

The maximum age a non-Spouse Dependent can be to maintain eligibility under the terms of the Plan, and as defined in the SPD.

“Maintenance Therapy”

A treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life, or therapy that is performed to maintain or prevent deterioration of a Chronic Condition.

“Maternity Services”

Includes prenatal and postnatal care, childbirth, and any complications associated with pregnancy.

“Maximum Lifetime Benefit”

The Maximum Lifetime Benefit is the maximum amount payable by the Plan per Member, if applicable, and listed in the Schedule of Benefits.

“Measurement Period”

The period during which an Employee's status as a PPACA Full-Time Employee (or not as a PPACA Full-Time Employee, as the case may be) is measured based upon reasonable administrative procedures that are consistent with regulations issued by the United States Department of the Treasury.

“Medical Director”

The Physician specified by the ASP, or his or her designee, and appropriately licensed in the practice of medicine in accordance with state law, who is responsible for medical oversight programs, including but not limited to Pre-Certification programs.

“Medically Necessary/Medical Necessity”

Medically Necessary means those services, supplies, equipment and facility charges that are not expressly excluded under this Agreement and are:

Medically appropriate, so that expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks;

Necessary to meet Your health needs, improve physiological function and required for a reason other than improving appearance;

Rendered in the most cost-efficient manner and setting appropriate for the delivery of the service;

Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities for which Coverage is requested;

Consistent with the Diagnosis of the condition at issue;

Required for reasons other than Your comfort or the comfort and convenience of Your Physician; and

Not Experimental or Investigational as determined by the Plan under the Plan's Experimental Procedures Determination Policy.

“Medicare”

Part A and Part B of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

“Member”

Any Subscriber or Dependent or Qualified Beneficiary (as that term is defined under COBRA) who enrolled for Coverage under this Agreement in accordance with its terms and conditions.

“Mental Illness” or “Mental Health”

Those conditions classified as “mental disorders” in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders but not including mental retardation.

“Non-Participating”

A Provider who has no direct or indirect written agreement with the Plan to provide Covered Services to Members.

“Nonresidential Treatment Program”

A program certified by the department of mental health involving structured, intensive treatment in a nonresidential setting.

“Open Enrollment Period”

Annual period in which an Eligible Employee and/or Dependent may enroll in coverage. Enrollment(s) made during this period are effective January 1st. Information is distributed by the Human Resources Department regarding Open Enrollment each fall.

“Orthotic Appliances”

Orthotic Appliances correct or support a defect of a body form or function.

“Out-of-Pocket Maximum”

The annual limit of a Member’s payments for Covered Services, as specified in the Schedule of Benefits.

“Participating”

A Provider or Pharmacy who has a contractual arrangement with the Plan for the provision of Covered Services to the Members.

“Peer-Reviewed Medical Literature”

A scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in two major American medical journals. Peer-Reviewed Medical Literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company, a device manufacturing company, or health vendor.

“Physician/Practitioner”

Means anyone qualified and licensed to practice medicine and surgery by the state in which services are rendered who has the Degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) Physician also means Doctors of Dentistry, Chiropractic and Podiatry when they are acting within the scope of their license.

“Plan”

City of Wichita Group Health Benefit Plan

“Plan Administrator”

The person, committee or entity designated under the Plan to administer the Plan. The Plan Administrator for the Plan is the City of Wichita.

“Plan Sponsor”

1) For the primary purpose of this document; an entity or person responsible for creating and maintaining the power of the Plan. 2) For the purpose of HIPAA; an entity entrusted with the management of property or with the power to act on behalf of and for the benefit of another. 3) (“City of Wichita”)

“Post-Service Appeal”

An appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.

“PPACA”

The Patient Protection and Affordable Care Act of 2010, as amended.

“PPACA Full-Time Employee”

An employee who the City has determined to be reasonably expected to average at least thirty (30) hours of service per week by application of reasonable administrative procedures utilizing Measurement Periods that are consistent with regulations issued by the United States Department of the Treasury.

“Pre-Certification”

The Plan has given approval on a Pre-Service request for payment for Covered Services to be rendered by a Participating or Non-Participating Provider or Pharmacy. Pre-Certification does not guarantee payment if You are not eligible for Covered Services at the time the service is provided.

“Prescription Drug(s)”

Any medication or drug which is provided for outpatient administration; has been approved by the Food and Drug Administration; and under federal or state law, is dispensed pursuant to a prescription order (legend drug).

“Pre-Service Appeal”

An appeal for which an Adverse Benefit Determination has been rendered for a service that has not yet been provided and requires Pre-Certification.

“Prosthetic Devices”

Prosthetic Devices aid body functioning or replace a limb or body part. Prosthetic Devices can be either internally or externally placed.

“Provider”

A Physician, Hospital, or Ancillary Provider, Pharmacy or other duly licensed professional, health care facility, or practitioner, certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received.

“Qualified Medical Child Support Order” (“QMCSO”)

An issued order, judgment, decree or settlement agreement by a court of competent jurisdiction or issued through an administrative process established under State law and has the force and effect of law under applicable State law that requires a non-custodial parent to provide medical Coverage

for his/her child who might not otherwise be eligible for Coverage. A qualified order includes information regarding: 1) The Member's name and address; 2) The name and last known mailing address of the Alternate Recipient; 3) The name of the Plan the child will be Covered by; 4) A reasonable description of the type and scope of health Coverage provided under the Plan; 5) The period of time to which the order applies; and 6) The order must be signed by the Judge, Commissioner or Magistrate.

Contact Customer Service if You would like to see a complete copy of the procedures for determining whether an order constitutes a QMCSO.

“Reconstructive Surgery”

Surgery which is incidental to an Injury, Illness or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body. (A congenital anomaly is a defective development or formation of a part of the body, when such defect is determined by the treating Physician to have been present at the time of birth.) The definition of Reconstructive Surgery includes the following: reconstructive surgery following a mastectomy, including on the opposite breast to restore symmetry and Prosthetic Devices/implants or reduction mammoplasty; and reconstructive surgery for a Covered newborn.

“Residential Treatment Facility”

A facility licensed by the applicable state or approved by the Joint Commission on Accreditation of Health Care Organizations; such as a general community Hospital with approved mental health beds, a psychiatric Hospital, a facility for the chemically dependent, or a Community Mental Health Center.

“Residential Treatment Program”

A program certified by the department of mental health involving residential care and structured, intensive treatment.

“Retiree”

A former Eligible Employee of the City of Wichita who meets the definition of retired employees to whom the City of Wichita offers Coverage under this SPD.

“Semi-Private Accommodations”

A room with two (2) or more beds in a Hospital. The difference in cost between Semi-Private Accommodations and private accommodations is Covered only when private accommodations are Medically Necessary.

“Service in the Uniformed Services”

One of the following: (i) the performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty, active and inactive duty for training, National Guard duty under Federal law, (ii) a period for which a Subscriber is absent from a position of employment for the purpose of an examination to determine the fitness of the Subscriber to perform any such duty, (iii) a period for which a Subscriber is absent from employment to perform funeral honors duty as authorized by law, and (iv) service as an intermittent disaster-response appointee upon activation of the National Disaster Medical System or as a participant in an authorized training program.

“Skilled Nursing Facility (“SNF”)

A facility certified by Medicare to provide inpatient skilled nursing care, rehabilitation services or other related services. The term “Skilled Nursing Facility” does not include a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily Custodial Care, including training in Activities of Daily Living.

“Social Setting Detoxification”

A program in a supportive non-Hospital setting designed to achieve detoxification, without the use of drugs or other medical intervention, to establish a plan of treatment and provide for medical referral when necessary.

“Special Enrollment Period”

The period after the regular Enrollment Period during which an individual is allowed to enroll for Coverage subject to the terms of SPD.

“Spouse”

A Subscriber’s Spouse or eligible former Spouse as defined by applicable state law or court decree.

“Stability Period”

The period that follows, and is associated with, a Measurement Period (and related administrative period) during which an Employee's status as a PPACA Full-Time Employee (or not as a PPACA Full-Time Employee, as the case may be) will generally be locked in place based upon reasonable administrative procedures that are consistent with regulations issued by the United States Department of the Treasury.

“Subscriber”

The Eligible Employee or Retiree who meets all the requirements as set forth in this SPD and who has elected the Plan’s Coverage for himself/herself and any eligible Dependents through submission of an Employee Enrollment/Change Form and for whom, or on whose behalf, contributions have been received by the Plan.

“Substance Abuse”

The psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

“Therapeutic Injections and IV Infusions”

Prescription medications given by injection or IV infusion (specifically excluding blood) by a duly-licensed Provider or injected by the Member.

“Urgent Care”

A condition that requires prompt medical attention due to an unexpected Illness or Injury. These conditions may also constitute Emergencies in those situations that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe immediate medical care is required.

“Urgent Care Appeal”

An Appeal for which a requested service requires Pre-Certification, an Adverse Benefit Determination has been rendered, the requested service has not been provided, and the application of non-Urgent Care Appeal time frames could seriously jeopardize: (a) the life or health of the

Member or the Member's unborn child; or (b) the Member's ability to regain maximum function. In determining whether an Appeal involves Urgent Care, the Plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

“Utilization Review”

A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, Pre-Certification, concurrent review, case management, and discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of Coverage.

“You or Your”

A Member Covered under this SPD.

USING YOUR BENEFITS

Membership Identification (“ID”) Card

Every Member receives a membership ID card. Carry Your ID card with You at all times, and present it every time You request or receive services. The ID card is needed for Providers to bill the Plan for charges other than Copayments, Coinsurance, and non-Covered Services. If You do not show Your ID card, the Providers cannot identify You as a Member of the Plan, and You may receive a bill for services. If Your ID card is missing, lost, or stolen, contact the Plan’s Human Resource Department at 316-268-4531 or the ASP. Contact information is listed on Your ID card and in the Additional Information section following this document. If Your Dependents are Covered, You will receive an additional ID card for each Covered Dependent. Possession and use of an ID card is not an entitlement to Coverage. Coverage is subject to verification of eligibility and all the terms, conditions, limitations and exclusions set out in the Agreement.

Health Services Rendered by Participating Providers

A Member has access to the services of a Participating Provider of their choice within the Provider network when receiving In-Network Covered Services, subject to the terms, conditions, exclusions and limitations of the Agreement. Coverage for services described in this SPD and the Schedule of Benefits include services that (a) are Medically Necessary and (b) are provided by or under the direction of a Participating Provider and (c) are Pre-Certified, if required, in advance. The telephone number for Pre-Certification is listed on Your ID card and in additional information, which is attached to this SPD. Participating Providers are contractually obligated to file all claims for You.

It is the Member’s responsibility to verify the participation status of Providers. A Member should not assume that a Provider, whom a Participating Provider may recommend, would always be another Participating Provider. The Member is responsible for verifying the status of the Provider by contacting the Customer Service Department of the ASP.

Coverage for services is subject to timely payment of the premium required for Coverage under the Plan and payment of the Copayment, Coinsurance and/or Deductible specified for any service. Questions regarding Coverage for services or Provider participation status should be directed to the Plan, not the Provider.

Coverage for Services by Non-Participating Providers

A Non-Participating Provider may or may not complete and file the claim form for You. If not, You may obtain a Non-Participating claim form from the ASP’s Customer Service Department within fifteen (15) days from the date the ASP receives notice of a claim from You. If a Non-Participating claim form is not provided to You within fifteen (15) days after the ASP receives notice of a claim, You shall be deemed to have complied with the requirements of the Plan as to proof of loss upon submitting written proof covering the occurrence, character, and extent of loss, within the time fixed for filing a claim.

It is your responsibility to provide any information that is necessary to make a prompt and fair evaluation of your claim. A Non-Participating Provider claim must be filed within ninety (90) days from date of service. However, failure to file the claim within the ninety (90) day period shall not invalidate or reduce the claim, if it was not reasonably possible to provide notice or proof within the ninety (90) days. A claim will not be denied based upon the Member’s failure to submit a claim within the ninety (90) day period. However, claims may not be accepted, except in the absence of

legal capacity of the claimant, when proof of loss is submitted to the Plan more than fifteen (15) months from the date services were provided by the Non-Participating Provider.

Non-Participating Provider services rendered at a Participating Provider Facility

When You incur a Covered Charge by a Non-Participating Provider as a result of treatment for a sickness or injury rendered by a Participating Provider and/or Participating Provider Facility, Covered services are subject to the Participating Provider level of benefit shown on the Schedule of Benefits. Any remaining expenses charged to You due to the difference between the Non-Participating Provider's Allowable Charge and Non-Participating Provider's billed charge are reimbursed by the Plan.

Non-Participating Provider Fees

Payment for Covered Services provided by Non-Participating Providers is limited to the lesser of the billed charge or the Out-of-Network rates listed below less applicable Copayments, Coinsurance and/or Deductibles. These rates are calculated as a multiple of the Medicare fee schedule for Physicians, Hospitals, outpatient facilities, ancillary Providers and other Providers. These rates may be adjusted from time to time.

If the amount You are charged for a Covered Service is equal to or less than the Out-of-Network rate, the charge should be completely covered by Your Out of Network benefit, except for any Copayment, Coinsurance, and/or Deductible payments You must make. However, if the amount You are charged is in excess of the Out-of-Network rate for a particular Covered Service, you will be responsible for paying any amounts in excess of the rates listed below, in addition to any applicable Copayment, Coinsurance, and/or Deductible payments.

Non-Participating Physician and Other Health Care Professional Fees

The Out-of-Network rate is equivalent to 100% of the national average Medicare rate, based on the previous year Resource Based Relative Value Scale ("RBRVS") fee schedule for Physician and other health care profession services, as such services are defined in the American Medical Association's Current Procedural Terminology ("CPT") manual. For Physician and other health care profession services not valued in RBRVS, other Medicare or nationally recognized schedules will be used. For CPT codes developed after previous year, the rate will be calculated using the assigned Relative Value Units ("RVU") and the previous year Medicare conversion factor. Payment for immunizations and injectable drugs will be at 100% of the First Data Bank Average Wholesale Price ("AWP"). Payment for anesthesia services will be 200% of the previous year national average Medicare rate per 15 minute increment. Payment for Durable Medical Equipment ("DME"), prosthetics, orthotics and supplies ("DMEPOS") will be at the previous year DMEPOS ceiling limit. Payment for Laboratory services will be at the previous year Medicare Clinical Laboratory Fee Schedule. If there is no corresponding rate, as described above, for a particular service, the Plan shall provide payment at 50% of billed charges. The Plan reserves the right to apply proprietary payment guidelines, claim adjudication procedures and billing instructions in conjunction with the determination of the Out-of-Network rates.

Non-Participating Facility Fees

The Out-of-Network rate is equivalent to 100% of the Medicare base rate for facility charges. Payment for inpatient services will be based on Diagnosis Related Group ("DRG") rates. Payment for outpatient services will be based on Ambulatory Payment Classification ("APC") rates. Payment for services provided within an ambulatory surgical center will be based on Ambulatory

Surgical Center (“ASC”) group rates. If there is no corresponding DRG, APC or ASC rate for a particular service, the Plan shall provide payment at 50% of billed charges. The Plan reserves the right to apply proprietary payment guidelines, claim adjudication procedures and billing instructions in conjunction with the determination of the Out-of-Network rates.

Please note that Physician and Hospital charges typically are not regulated. Billed charges can vary tremendously from one Provider to the next, so please make sure you are aware of the billed charge for services you want to receive from Non-Participating Providers.

Pre-Certification

Pre-Certification is required for certain Covered Services as determined by the Plan, such services include Hospital Admissions and related services, selected outpatient procedures, and all transplants. It is the Member’s responsibility to verify that Pre-Certification has been obtained from the Plan prior to receiving Covered Services. A list of current Pre-Certification procedures is provided after this document. To request a copy, contact the Plan’s Customer Service Department’s telephone number listed on Your ID card or by visiting the Plan’s website.

Any new, additional or extended services not Covered under the original Pre-Certification will be Covered only if a new Pre-Certification is obtained. All services identified in this SPD are subject to all of the terms, conditions, exclusions and limitations of the Plan, even if the Participating Provider requests the Pre-Certification on behalf of the Member.

Failure to obtain Pre-Certification may result in a reduction of benefits. Any penalty applied because of failure to Pre-Certify Covered Services does not apply to the Out-of-Pocket Maximum, the Deductible or Coinsurance amount. It is the Member’s responsibility to verify that Pre-Certification has been obtained before receiving services.

It is important to note that under the terms of the Plan, Pre-Certification only determines Medical Necessity and appropriateness, all other terms of the Plan are then applied. If the Plan Pre-Certifies Covered Services, the Plan shall not subsequently retract the Pre-Certification after the Covered Services have been received, or reduce payment unless: (1) Such Pre-Certification is based on a material misrepresentation or omission about the Member’s health condition or the cause of the health condition; or (2) the Plan terminates before the health care services are provided; or (3) the Member’s Coverage under the Plan terminates before the health care services are provided.

Second Opinion Policy

A Member may seek a second medical opinion or consultation from any Provider. A Member should not assume that a Provider, whom a Participating Provider may recommend, would always be another Participating Provider. The Member will be responsible for the cost of services received from a Non-Participating Provider as outlined in the Schedule of Benefits and subject to the terms, conditions, exclusions and limitations of the SPD.

Copayments, Coinsurance and Deductibles

You are responsible for paying Copayments to Providers at the time of service. The Provider may bill You at a later time for the Coinsurance amounts that are Your responsibility under the terms of the Plan as determined by the contracted rates that have been established between the Plan and the Participating Providers or as determined by the Plan’s Non-Participating Provider fee schedule when services are rendered by a Non-Participating Provider. You must meet the applicable Deductible, as described in your Schedule of Benefits, before benefits will be payable to Providers

on Your behalf. Specific Copayments, Coinsurance amounts and Deductibles are listed in the Schedule of Benefits. A Copayment is defined as a dollar amount, while Coinsurance is typically defined as a percentage of Eligible Expenses.

Deductible: A Deductible is the amount of covered expenses, which must be paid each Calendar Year by a Member before benefits will be payable to Providers on Your behalf. Copayments do not count toward the Deductible. The individual Deductible applies separately to each Member. The family Deductible applies collectively to all Members in the same family. When two Members within the family have met their individual Deductibles the family Deductible is satisfied, and no further Deductible will be applied for any covered family Member during the remainder of the Calendar Year.

Out-of-Pocket Maximum: An Out-of-Pocket Maximum is the amount of covered expenses, which must be paid each Calendar Year by a Member before the payment percentage of the Plan increases. Copayments do not count toward the Out-of-Pocket Maximum in the Select Plan Option, and Copayments and Deductibles do not count toward the Out-of-Pocket Maximum in the Premium Plan Option. The individual Out-of-Pocket Maximum applies separately to each Member. The family Out-of-Pocket Maximum applies collectively to all Members in the same family. When two Members within the family have met their individual Out-of-Pocket Maximum the family Out-of-Pocket Maximum is satisfied. The Plan will pay 100% (except for Copayments and the charges excluded) for any covered family Member during the remainder of the Calendar Year.

How to Contact The Plan

Throughout this Agreement, You will find that the Plan encourages You to contact the Plan or ASP for further information. Whenever You have a question or concern regarding Covered Services or any required procedure, you may contact the ASP at the telephone number or website on the back of Your ID card or the Additional Information provided following this document.

Telephone numbers and addresses to request review of denied claims, register Complaints, place requests for Pre-Certification, and submit claims are listed in the additional information included in this SPD.

Participating Provider Hold Harmless

Participating Providers may not balance bill charges over allowed contracted amount. This provision shall not prohibit the Provider from collecting Coinsurance, Deductibles or Copayments, as specifically provided in the SPD, or fees for non-Covered Services delivered on a fee-for-service basis to You. The Provider hold harmless provision shall not prohibit a Provider and You from agreeing to continue services solely at Your expense, as long as the Provider has clearly informed You that the Plan may not cover or continue to cover a specific service or services. Except as provided herein, this provision does not prohibit the Provider from pursuing any available legal remedy, including but not limited to, collecting from any insurance carrier providing Coverage to a Member.

Plan Has Authority to Grant Coverage

Only Medically Necessary services are Covered under the Agreement. The fact that a Physician or other Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an Injury, Illness or Substance Abuse, or Mental Illness does not mean that the procedure or treatment is Covered under the Agreement. The Plan shall have the right, subject to Your rights in this SPD, to interpret the benefits of the SPD, Plan Amendments or

Summary of Material Modification in making factual determinations related to the benefits, and Members; and in construing any disputed or ambiguous terms. In accordance with all applicable law, the Plan reserves the right at any time, to change, amend, interpret, modify, withdraw or add benefits to, or terminate this Plan. The Plan may, in certain circumstances, cover services that would otherwise not be Covered. The fact that the Plan does so in any particular case shall not in any way be deemed to require it to do so in other similar cases.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

Subscriber Eligibility - To be eligible to be enrolled You must meet one of the following categories:

The following categories of Employees are eligible for benefits:

- Full-time Employees regularly scheduled to work thirty (30) hours per week;
- Part-time Employees hired before December 27, 1986;
- Certain contract Employees, as defined by the Employer,
- Management interns;
- Police and Fire Recruits;
- Retirees under 65; and
- Elected Officials.

In addition, and notwithstanding the above, if an employee does not meet the conditions above, but is otherwise determined to be a PPACA Full-Time Employee, such employee shall be an Eligible Employee under this Plan for the Stability Period for which he or she is determined to be a PPACA Full-Time Employee.

Notwithstanding the foregoing, an employee who commences his or her Stability Period (generally the Plan Year) as a PPACA Full-Time Employee and who elects coverage under the Plan for such Stability Period shall remain an Eligible Employee for the remainder of such Stability Period, regardless of whether such Employee transfers into a position that would no longer be eligible for the Plan under this Section; provided, however, that such an employee may be subject to an increased premium for coverage under the Plan as a result of the change in position.

Dependent Eligibility - To be eligible to be enrolled under this Agreement as a Dependent, an individual must:

1) Be the lawful Spouse of the Subscriber or be a child of the Subscriber or the Subscriber's Spouse including:

- Children to age twenty-six (26) who are either the birth children of the Subscriber or the Subscriber's Spouse or legally adopted by or placed for adoption with the Subscriber or Subscriber's Spouse;
- Children to age twenty-six (26) for whom the Subscriber or the Subscriber's Spouse is required to provide health care Coverage pursuant to a Qualified Medical Child Support Order.

A (QMCSO) is a medical child support order issued by a court, which has jurisdiction, under state law requiring a non-custodial parent to provide medical coverage for his or her children that specifies the individuals involved, the type of coverage to be provided and the plan that provides the coverage. The QMCSO may not require the Plan to provide any type or form of benefit, or any benefit option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act.

- Children to age twenty-six (26) for whom the Subscriber or the Subscriber's Spouse is the court-appointed legal guardian; and

- Coverage will be extended for children beyond the age twenty-six (26) who meet the Eligibility requirements, are mentally or physically incapable of earning a living and who are chiefly dependent upon the Subscriber or the Subscriber's Spouse for support and maintenance, provided that: the onset of such incapacity occurred before age eighteen (18) proof of such incapacity is furnished to the Plan by the Subscriber upon enrollment of the Dependent child or at the onset of the Dependent child's incapacity prior to reaching the Limiting Age and annually thereafter.

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

Retirees (under age of 65)

All City of Wichita Retirees are eligible for this plan until reaching the age of 65 or becoming eligible for Medicare whichever occurs first. Retirees over the age of 65 are not eligible for City of Wichita Medical Coverage.

Retiree Coverage: Retirees and their Dependents are eligible for Coverage, so long as premiums are paid and the Retiree was enrolled for coverage at the time the Retiree's employment terminated and remained enrolled.

Spouse and Dependent Coverage: When the Retiree turns age 65, the Spouse may remain on the plan until reaching age 65 and/or Dependents may remain on the plan until reaching age of 26. Spouses who turn 65 are no longer eligible for coverage even if their Spouse-Retiree is younger. Refer to section on Dependent eligibility for more details.

Surviving Spouse of the Retiree: Surviving Spouse of the Retiree can remain covered to age 65, so long as premiums are paid and the Spouse was covered at the time of the Retiree's death.

Deferred Retiree Coverage: An employee who terminates employment with the City and defers retirement can continue to be covered so long as the Retiree was enrolled for coverage at the time the employee's employment terminated, the employee remains enrolled, and the premiums are paid. When an employee defers retirement and does not continue coverage, there is no coverage available for the Retiree, Spouse or dependents. Exercising COBRA continuation is not a continuation of the group plan and loss of COBRA does not qualify as an event to rejoin Retiree Medical group.

Persons Not Eligible to Enroll

A person who fails to meet the eligibility requirements specified in this SPD shall not be eligible to enroll or continue enrollment with the Plan.

A person whose Coverage under this Agreement was terminated due to a violation of a material provision of this Agreement shall not be eligible to enroll with the Plan for Coverage under this Agreement.

Late Enrollees are not eligible to enroll except during the next Open Enrollment Period, or during a Special Enrollment Period.

Enrollment

All individuals meeting the eligibility requirements of this section may enroll with the Plan for Coverage during the Open Enrollment Period or a Special Enrollment Period.

Any new employee may enroll with the Plan for Coverage under this Agreement within thirty (30) days after becoming eligible. If the employee fails to submit an Employee Enrollment/Change Form for purposes of enrolling with the Plan for Coverage within thirty (30) days after becoming eligible, he or she is not eligible to enroll until the next Open Enrollment Period unless there is a special enrollment.

A special enrollee may enroll with the Plan for Coverage as provided below.

Eligible Employees or their Dependents who do not enroll during an initial eligibility period, or within thirty (30) days of first becoming eligible for Coverage are not eligible to enroll until the next Open Enrollment Period, unless they are eligible to enroll as a special enrollee, as described below.

Special Enrollment

Special Enrollment Due to Loss of Other Coverage Subject to the conditions set forth below, an Eligible Employee and his or her Dependents may enroll in the Plan if the Eligible Employee waived initial Coverage under the Plan at the time Coverage was first offered because the Eligible Employee or Dependent had other Coverage at the time Coverage under the Plan was offered and the Eligible Employee's or Dependent's other Coverage was:

- COBRA continuation Coverage that has since been exhausted; or,
- If not COBRA continuation Coverage, such other Coverage terminated due to a loss of eligibility for such Coverage or employer contributions toward the other Coverage terminated. The term "loss of eligibility for such Coverage" includes a loss of Coverage due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment. This term does not include loss of Coverage due to failure to timely pay required contributions or premiums or loss of Coverage for cause (i.e., fraud or intentional misrepresentation).

Required Length of Special Enrollment An employee and his or her Dependents must request special enrollment in writing no later than **sixty (60)** days from the date that the other Coverage was lost.

Effective Date of Coverage If the employee or Dependent enrolls within the **sixty (60) day** period, Coverage under the Plan will become effective the date of the event.

Enrollment Due to New Dependent Eligibility Subject to the conditions set forth below, an Eligible Employee and his or her Dependents may enroll in the Plan if the Eligible Employee has acquired a Dependent through marriage, birth, adoption or placement for adoption.

- Non-Participating Eligible Employee. An Eligible Employee who is eligible but has not yet enrolled may enroll upon marriage or upon the birth, adoption or placement for adoption of his or her child (even if the child does not enroll).

- **Non-Participating Spouse.** If You are enrolled, Your Spouse may enroll at the time of marriage to You, or upon the birth, adoption or placement for adoption of his or her child (even if the new child does not enroll).
- **New Dependents of Subscriber.** A child who becomes a Dependent of a Subscriber as a result of marriage, birth, adoption or placement for adoption may enroll at that time. Existing children of a Subscriber may be enrolled at the same time.
- **New Dependents of non-enrolled Eligible Employee.** A child who becomes a Dependent of a non-enrolled Eligible Employee as a result of marriage, birth, adoption or placement for adoption may enroll at that time but only if the non-enrolled Eligible Employee is eligible for enrollment and enrolls at the same time.

Required Length of Special Enrollment An Eligible Employee and his or her Dependents must complete special enrollment in writing no later than **sixty (60)** days from the date of marriage, birth, adoption or placement for adoption.

Effective Date of Coverage Coverage shall become effective the day of the qualifying event.

Other Mid-Year Events: The Cafeteria Plan for the Employees of City of Wichita ("Cafeteria Plan") also allows for certain mid-year changes in enrollment. This Plan will allow for enrollment changes in accordance with the Cafeteria Plan. Those mid-year enrollment change events are described in the Cafeteria Plan, but generally include: (i) leaves of absence; (ii) loss of Dependent eligibility; (iii) a gain of coverage eligibility under another employer's plan; (iv) reduction in hours before thirty (30) hours per week without a loss of eligibility under this Plan; (v) special or annual enrollment in a qualified health plan offered under a PPACA health insurance exchange; (vi) changes required by certain judgments, decrees, and orders; (vii) changes as a result of Medicare or Medicaid eligibility or ineligibility; (viii) changes in cost or coverage under the Plan; and (ix) changes in coverage under another employer's plan.

Notification of Change in Status: A Subscriber must notify the Plan of any changes in status or the status of any Dependent within **thirty (30) (sixty [60])**, effective January 1, 2016) days after the date of the qualifying event. This includes the "Other Mid-Year Events" allowed under the Cafeteria Plan. This notification must be submitted on a written Employee Enrollment/Change Form to the Plan. Events qualifying as a change in status include, but are not limited to, changes in address, employment, divorce, marriage, dependency status, Medicare eligibility or Coverage by another payer. The Plan should be notified within a reasonable time of the death of any Member.

Effective Date

During Open Enrollment Period: An Eligible Employee or Retiree, and their Eligible Dependent(s), who enroll during an Open Enrollment Period shall be Covered as of the first (1st) day of January following the date that he or she completes the application for coverage, so long as the Plan receives the employee's completed Employee Enrollment/Change Form within the Open Enrollment Period specified by the City of Wichita. Employees wishing to enroll Dependents must provide appropriate documentation during the Open Enrollment Period for new coverage. Such documentation, may include, but is not limited to court order requiring Dependent coverage, marriage license, adoption agreement, etc.

Newly Hired Employees: A newly hired Eligible Employee, and their Eligible Dependent(s), shall be Covered upon the first (1st) day of the calendar month that follows the month of the Eligible Employee's date of hire, so long as the Plan receives the employee's completed Employee Enrollment/Change Form within thirty (30) days of becoming eligible for Coverage. Employees wishing to enroll Dependents must provide appropriate documentation within sixty (60) days of becoming eligible for new coverage. Such documentation, may include, but is not limited to court order requiring Dependent coverage, marriage license, adoption agreement, etc.

Newly Eligible Employees: An Eligible Employee, and their eligible Dependent(s), who become eligible for Coverage during the Plan year, shall be Covered as of the first (1st) day of the month following the date that he or she first becomes eligible so long as the Plan receives the employee's completed Employee Enrollment/Change Form within thirty (30) days of becoming eligible for new coverage. Employees wishing to enroll Dependents must provide appropriate documentation within sixty (60) days of becoming eligible for new coverage. Such documentation, may include, but is not limited to court order requiring Dependent coverage, marriage license, adoption agreement, etc.

Special Enrollees: Special enrollees shall be Covered under this Agreement as provided in this Section. Employees wishing to enroll Dependents must provide appropriate documentation within sixty (60) days of becoming eligible for new coverage. Such documentation, may include, but is not limited to court order requiring Dependent coverage, marriage license, adoption agreement, etc.

Member Effective Date for Dependents

Eligible Dependents who are special enrollees shall be Covered as stipulated in the Special Enrollment Section provided that a child born to the Subscriber or Subscriber's Spouse is automatically Covered for the treatment of Injury or Illness, including medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care, for the first thirty (30) days from the date of birth. To the extent permitted by applicable state law, additional premium shall be paid for this Coverage. For Coverage to continue beyond the first thirty (30) days, application to add the child as a Dependent must be received within sixty (60) days the date of birth. Upon notification, if additional forms are required the Member will be provided all forms and instructions necessary to enroll the newly born child and an additional ten (10) days from the date the forms and instructions are provided in which to enroll the newly born child.

An adopted child is Covered from the date of birth if a petition for adoption is filed within sixty (60) days of the birth of such child or from the date of placement for the purpose of adoption if a petition for adoption is filed within sixty (60) of placement of such child. Such Coverage shall continue until the legal adoption occurs or the date that the placement is disrupted prior to legal adoption and the child removed from placement. In this section, placement means in the physical custody by the adoptive parent.

Dependents eligible for Coverage as a result of a Qualified Medical Child Support Order ("QMCSO") shall be Covered as of the date specified in the order. If no date is specified in the order, Coverage shall be effective as of the date the order is issued by the court. In addition, a Subscriber, a state agency, or an Alternate Recipient may enroll a Dependent child pursuant to the terms of a valid QMCSO. A child who is eligible for Coverage pursuant to a QMCSO may not enroll Dependents for Coverage under the Plan.

Dependent Coverage under the Plan is subject to payment of the required contribution by the Subscriber, if any contribution is required. In the case of a child who is eligible for Coverage

pursuant to a QMCSO, payment of the required contribution is to be made for such child, by the custodial parent or legal guardian of such child, or by a state agency. The Plan will notify the City of the amount of the required total premium payable to the Plan. Upon agreement by the Plan and the City, the parties may change the required premium contribution of Subscribers.

TERMINATION OF COVERAGE

Termination of Coverage For Members

Your Coverage shall terminate, on the last day of the month for which the required premium is paid, if any one of the following events occurs:

You no longer meet the eligibility requirements set forth in this SPD, including, without limitation, upon termination of the Subscriber from Employment; the Member entering active military service; divorce or legal separation from the Subscriber; death; or when a Dependent child reaches the Limiting Age.

You are retired and have reached age 65; see Retiree Coverage under Eligibility, Enrollment, and Effective Dates.

You fail to pay premiums. NOTE: In the event that the Plan has not received payment of premium at the end of the **thirty-one (31)** days' notice period (and any grace period, if applicable), you will be retroactively terminated to the date Covered by Your last paid premium. You will be responsible for the value of services rendered during **the thirty-one (31)** days' notice period (and any grace period, if applicable).

Your Coverage will terminate immediately if you participate in fraudulent or criminal behavior, including but not limited to:

Performing an act or practice that constitutes fraud or intentionally misrepresenting material facts including using Your identification card to obtain goods or services which are not prescribed or ordered for You or to which You are otherwise not legally entitled. In this instance, Coverage for the Subscriber and all Dependents will be terminated.

Allowing any other person to use Your identification card to obtain services. If a Dependent allows any other person to use his/her identification card to obtain services, the Coverage of the Dependent who allowed the misuse of the card will be terminated. If the Subscriber allows any other person to use his/her identification card to obtain services, the Coverage of the Subscriber and his/her Dependents will be terminated.

Knowingly misrepresenting or giving false information on any enrollment application or any other form required by the Plan.

Termination of Coverage without Notice. Your Coverage shall immediately terminate if the Plan terminates.

Effect of Termination.

If a Member's coverage under this Plan is terminated, all rights to receive Covered Services shall end on the date indicated in the "Termination of Coverage for Members" section above.

Identification cards are the property of the Plan and, upon request, shall be returned to the Plan Sponsor. Identification cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.

NOTE: It is the employee's responsibility to notify the Human Resources Department in writing within 30 days when an employee or a Covered Dependent has a qualifying event occur and that employee or Dependent is no longer eligible for benefits. **Any claims paid after that date must be reimbursed to the Plan.**

CONTINUATION RIGHTS

Continuation of Coverage Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, Your Dependent Spouse, and Your Dependent children could become qualified beneficiaries if coverage under the group benefits plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You are an Employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because any of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than Your gross misconduct.

If You are the Spouse of an Employee, You will become a qualified beneficiary if You lose Your coverage under either plan because any of the following qualifying events happens:

- The Employee dies;
- The Employee’s hours of employment are reduced;
- The Employee’s employment ends for any reason other than his or her gross misconduct;
- The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from the Employee.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The Employee dies;
- The Employee’s hours of employment are reduced;
- The Employee’s employment ends for any reason other than his or her gross misconduct;
- The Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a “Dependent child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to *[enter name of employer sponsoring the Plan]*, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's Spouse, surviving Spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end

of employment or reduction of hours of employment, death of the employee, or employee's becoming entitled to Medicare benefits (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice Of Some Qualifying Events to the Human Resources Department

For other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), You must provide notice to the City of Wichita Human Resources Department at 455 N. Main Street, Wichita, KS 67202, **sixty (60)** days after the qualifying event occurs or, if later, the date coverage would be lost as a result of the qualifying event. The notice must include all of the following: (a) the name of the Plan, (b) a description of the qualifying event, (c) the date the qualifying event occurred, and (d) the name of the covered Employee and all Dependents. Failure to provide timely notice may affect Your right to elect continuation coverage.

EMPLOYERS' AND PLAN ADMINISTRATOR'S NOTIFICATION OBLIGATIONS

The Plan Administrator shall provide, at the time of commencement of coverage under the Plan, written notice to each Subscriber and to the Spouse of the Subscriber (if any) of their rights to continuation coverage. The Plan may satisfy this obligation by furnishing a single notice addressed to both a Subscriber and the Subscriber's Spouse if they both reside at the Subscriber's address, and the Spouse's coverage commences on or after the date on which the Subscriber's coverage commences, but not later than the date by which this general notice must be provided. No separate notice is required to be sent to Dependent children who share a residence with a Subscriber or a Subscriber's Spouse. This general notice shall be provided not later than the earlier of: (i) ninety (90) days after such individual's coverage commencement date under the Plan, or (ii) the date on which the Plan Administrator is required to furnish a COBRA election notice as described in this Section.

The Employer shall notify the Plan Administrator or its designee in the event of a Subscriber's death, termination of employment (other than gross misconduct), reduction in hours, or entitlement to Medicare benefits within thirty (30) days after the later of: (i) the date of the qualifying event or (ii) the date that the qualified beneficiary would lose coverage due to the qualifying event.

The Subscriber and the Subscriber's Dependent(s) shall be notified by the Plan Administrator or its designee of their right to elect continuation coverage: (i) in the event of the Subscriber's death, termination, reduction in hours or entitlement to Medicare benefits, and (ii) if the Subscriber is notified by the Plan Administrator or its designee initially, in the event of divorce or legal separation of the Subscriber from the Subscriber's Spouse, a total disability, or in the event of a child ceasing to be a Dependent child under the generally applicable requirements of the Plan, within fourteen (14) days of the date on which the Plan Administrator or its designee was notified of these qualifying events. Election form shall be sent by U.S. Mail, postage pre-paid, to the last known address of the qualified beneficiaries unless the Plan Administrator has been notified in writing to the contrary. The last known address shall be deemed to be the most recent address contained in the Subscriber's/former Subscriber's personnel file. In the event the Subscriber/former Subscriber changes address, it is his or her responsibility to notify the Plan Administrator of any change in address and the Plan Administrator shall not be responsible for notices sent to the wrong address if the more recent address was not provided in the above manner. Notification to an Subscriber/former Subscriber who elected spousal coverage shall be sent with an envelope marked "Mr. and Mrs. John Smith." Election forms sent to an Subscriber/former Subscriber that has one or more children/Dependents covered shall be addressed to the Subscriber (if the Spouse was not covered) or to the Subscriber and Spouse (if spousal coverage was elected), and each shall be deemed to include notification to any Dependent children, unless the Plan Administrator has actual knowledge of a different address for a Dependent child before the date the election form is mailed and provided further that any such notification to the Plan Administrator was in writing sent via either U.S. Mail or facsimile.

In addition, if a Subscriber or Dependent is not entitled to receive continuation coverage, he or she will be notified of this and will be provided with an explanation as to why he or she is not entitled to this continuation coverage. This notice shall be provided within fourteen (14) days of the date that the Plan Administrator was provided with the notice of the purported qualifying event.

How Is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's entitlement to Medicare benefits (Part A, Part B, or both), divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a Subscriber becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

Notwithstanding the foregoing, COBRA continuation coverage shall end earlier than the times periods described in the prior paragraphs when: (a) the qualified beneficiary is or first becomes eligible for Medicare benefits after the COBRA election; (b) the City ceases to offer any group health plans to any employee; (c) the required monthly contribution for coverage is not received by the Plan Administrator or its designee within thirty (30) days following the date it is due; or (d) the Plan Administrator could otherwise terminate coverage for similarly situated non-COBR beneficiary for cause (*e.g.*, in the case of submitting fraudulent claims to the Plan).

In the event a qualified beneficiary's continuation coverage terminates before the duration of continuation coverage (either 18, 29 or 36 months after the qualifying event), the Plan Administrator shall notify the qualified beneficiary of the early termination date and the reason for early termination of continuation coverage. Such notice will be provided as soon as practicable following the Plan Administrator's determination that continuation coverage should terminate.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended, both of which are described in the following two paragraphs.

Disability Extension of 18-Month Period of Continuation Coverage

If You or anyone in Your family covered under a plan is determined by the Social Security Administration to be disabled and You notify the Plan Administrator in a timely fashion, You and Your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA

continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide this notice to the Department of Human Resources, 455 N. Main Street, Wichita, KS 67202. The notice must be provided within **60 days** of receiving the disability determination by the Social Security Administration but in no event later than the end of the first 18 months of continuation coverage. The notice also must include all of the following: (a) the name of the plan, (b) a copy of the Social Security determination, (c) a signed statement that the Social Security Administration has not made a subsequent determination to change the individual's disability status, and (d) the name of the Subscriber and all Dependents. Failure to provide timely notice may affect Your right to extend coverage beyond the regular 18-month period.

Second Qualifying Event Extension of 18-Month Period Of Continuation Coverage

If Your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, Your Spouse and Dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any Dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the Spouse or Dependent child to lose coverage under the plan had the first qualifying event not occurred. You must notify the plan within **sixty (60) days** after the second qualifying event occurs or, if later, the date coverage would be lost as a result of the qualifying event. The notice should be sent to the Human Resources Department, 455 North Main Street; Wichita, KS 67202 and must include all of the following: (a) the name of the Plan, (b) a description of the qualifying event, (c) the date the qualifying event occurred, and (d) the name of the Subscriber and all Dependents. Failure to provide timely notice may affect Your right to elect continuation coverage.

Continuation of Coverage Following FMLA

Once the Plan or the Plan Sponsor is notified or otherwise determines that an Employee is not returning to employment following a period of FMLA leave, the Employee may elect to continue his/her coverage under the COBRA continuation rules, as described herein. The qualifying event entitling the qualified beneficiaries to COBRA continuation coverage is the last day of the Employee's FMLA leave.

PAYMENT OF PREMIUM.

The Plan will determine the amount of premium to be charged for continuation coverage for any period, which will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as the Secretary of Labor may prescribe.

- The Plan may require a qualified beneficiary to pay a contribution for coverage that does not exceed one hundred two percent (102%) of the applicable premium for that period.
- For qualified beneficiaries whose coverage is continued as a result of total disability, the Plan may require the qualified beneficiary to pay a contribution for coverage that does not exceed one hundred fifty percent (150%) of the applicable premium for continuation coverage months 19-29.
- Contributions for coverage may, at the election of the qualified beneficiary, be paid in monthly installments.

If continuation coverage is elected, the monthly contribution for coverage for those months up to and including the month in which the election is made must be made within forty-five (45) days of the date of election. Failure to pay this premium on the date due shall result in cancellation of continuation coverage back to the initial date coverage would have terminated as a result of the qualifying event.

Without further notice from the Plan Administrator, the qualified beneficiary must pay each following monthly contribution for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the Plan Administrator within thirty (30) days of the payment's due date, continuation coverage will terminate. This thirty (30) day grace period does not apply to the first contribution.

No claim will be payable under this provision for any period for which the contribution for coverage is not received from or on behalf of the qualified beneficiary.

It is qualified beneficiary's responsibility to pay the premium on time. If the Plan Administrator provides a qualified beneficiary with payment reminders or payment coupons, but later ceases to do so, it still remains the qualified beneficiary's responsibility to make the premium payments on time even if the qualified beneficiary no longer receives the payment reminders or coupons, and even if the qualified beneficiary is not notified of the cessation of the payment reminders or coupons.

CONTINUATION COVERAGE AND OTHER OPTIONS. The continuation coverage elected by a qualified beneficiary is subject to all of the terms, conditions, limitations and exclusions which are applicable to the Plan offered to similarly situated Subscribers and their Dependents. The continuation coverage is also subject to the rules and regulations under COBRA. If COBRA permits qualified beneficiaries to add Dependents for continuation coverage, such Dependents must meet the definition of Dependent under the Plan. Continuation coverage may not be conditioned on evidence of good health. If the Plan provides an Open Enrollment Period during which similarly situated active employees may choose to be covered under another group health plan, or to add or eliminate coverage of family members, the Plan shall provide the same opportunity to qualified beneficiaries who have elected continuation coverage.

If continuation coverage under the Plan is elected by a qualified beneficiary under COBRA, expenses already credited to the Plan's applicable Deductible and Co-payment features for the year will be carried forward into the continuation coverage elected for that year. Similarly, amounts applied toward any maximum payments under the Plan will also be carried forward into the continuation coverage. Coverage will not be continued for any benefits for which Plan maximums have been reached.

Qualified beneficiaries may have other options available when they lose group health coverage such as Medicaid, other group health plan coverage, or coverage through a Health Insurance Marketplace. For example, a qualified beneficiary may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, a qualified beneficiary might qualify for lower costs on monthly premiums and lower out-of-pocket costs. Additionally, a qualified beneficiary might qualify for a 30-day Special Enrollment Period for another group health plan for which he or she may be eligible (such as a Spouse's plan), even if that plan generally does not accept Late Enrollees. Some alternatives to continuation coverage may be found at www.healthcare.gov.

If You Have Questions

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the Human Resources Department. For more information about Your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plan, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security

Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

Keep Your Plan Informed Of Address Changes

In order to protect Your family's rights, You should keep the Plan informed of any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to the Plan Administrator.

Plan Contact Information

If You have any questions about the medical plan or COBRA continuation coverage, please contact the Human Resources Department at 455 N. Main Street, Wichita, KS 67202.

IMPORTANT NOTICES

The Women's Health and Cancer Rights Notice

In accordance with the Women's Health and Cancer Rights Act of 1998 (WHCRA), the following coverage is offered to a Member who elects the following services in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Newborns' and Mothers' Health Protection Act

Group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that a Provider obtain authorization from the Plan or the Administrative Services Provider for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Military Leave of Absence

Any Subscriber who is covered under this Plan immediately prior to the Subscriber's covered absence for Service in the Uniformed Service shall be entitled to elect to continue coverage under this Plan, for the Subscriber and the Subscriber's Dependent(s), during the Subscriber's leave for Service in the Uniformed Service pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Such coverage is available if the Subscriber is absent from employment because of voluntary or involuntary performance of duty in the Army, Navy, Marine Corps, Air Force, Coast Guard, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, the reserve components of each of these services, and any other category of persons designated by the President of the United States in time of war or national emergency. Uniformed services also include certain types of service by members in the National Disaster Medical System and certain types of service by certain members of the Reserve Officers' Training Corps.

The Subscriber may elect to continue coverage by reason of Service in the Uniformed Services for himself and his covered Dependents. (Dependents do not have an independent right to elect USERRA continuation coverage.) The election period for continued coverage shall begin on the date the Subscriber gives the Plan Administrator advance notice that he is required to report for Uniformed Service (whether such service is voluntary or involuntary) and shall end sixty (60) days after the date the Subscriber would lose coverage under the Plan.

If the Subscriber is unable to give advance notice of Uniformed Service, the Subscriber may still be able to elect USERRA continuation coverage if the failure to give advance notice was because giving such notice was impossible, unreasonable, or precluded by military necessity. In such case, the election period shall begin on the date the Subscriber leaves for Uniformed Service and shall end on the earlier of: (i) the twenty-four (24) month period beginning on the date on which the Subscriber's absence for the Uniformed Service begins; or (ii) the date on which the Subscriber fails to return from Uniformed Service or apply for a position

of employment as provided under 20 CFR §§ 1002.115-123. For these purposes, "military necessity" occurs only when deemed to be so by a designated military authority as described in 20 CFR § 1002.86 and may include situations where a mission, operation, exercise or requirement is classified, or could be compromised or otherwise adversely affected by public knowledge. It may be impossible or unreasonable to give advance notice under certain circumstances such as when the Employer is unavailable or the Subscriber is required to report for Uniformed Service in an extremely short period of time.

The election of USERRA continuation coverage must be made on a form provided by the Plan Administrator and made within the sixty (60) day period described herein. An election is considered to be made on the date it is sent to the Plan Administrator. If timely elected, coverage shall be reinstated as of the date the Subscriber lost coverage due to absence for Service in the Uniformed Service and shall last for the period set forth below; provided that the Subscriber pays all unpaid costs for the coverage as described in this Section.

The maximum period of coverage for a Subscriber and/or Dependent under this provision shall be the lesser of: (1) the twenty-four (24) month period beginning on the date on which the Subscriber's military leave of absence begins; or (2) the day after the date on which the Subscriber fails to return from Uniformed Service or apply for a position of employment as provided under 20 CFR §§ 1002.115-123. Any Subscriber or Dependent who elects to continue coverage under this provision shall be required to pay one hundred and two percent (102%) of the applicable premium; provided, however, that any Subscriber who is on military leave for less than thirty-one (31) days shall not be required to pay more than the cost of coverage typically charged to similarly situated Subscribers (and their Dependents).

A Subscriber who is absent from work by reason of Service in the Uniformed Services may be eligible for COBRA Continuation Coverage. The USERRA Continuation Coverage provided in this Section shall not limit or otherwise interfere with those COBRA Continuation Coverage rights detailed above; provided, however, any USERRA Continuation Coverage provided under this Section shall run concurrently with any COBRA Continuation Coverage available under this Plan.

The Employer shall promptly reinstate Plan coverage when a Subscriber is reemployed after Service in the Uniformed Service; provided, however, a request to reinstate Plan coverage must be made by the Subscriber within thirty (30) days of reemployment (presuming the Subscriber has sought reemployment with the Plan in compliance with 20 CFR Part 1002, Subpart C). If no request is made within this time period, no coverage shall be reinstated under the Plan. When a Subscriber's coverage under the Plan is reinstated, he or she will not be subject to any exclusion or waiting periods. However, this rule does not apply to any conditions that were incurred or that were aggravated during the Subscriber's service in uniformed services.

The USERRA Continuation Coverage provided to a Subscriber serving in the Uniformed Services shall be identical to the coverage provided under the Plan to similarly situated persons covered by the Plan who are active. If coverage is modified under the Plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are covered under USERRA Continuation Coverage. Continuation coverage may not be conditioned on evidence of good health. If the Plan provides an open enrollment period during which similarly situated active employees may choose to be covered under another group health plan or under another benefit package within the Plan, or to add or eliminate coverage of family members, the Plan shall provide the same opportunity to individuals who have elected USERRA Continuation Coverage.

Family and Medical Leave of Absence

The Family and Medical Leave Act (FMLA) provides unpaid leaves of absence for: the birth of a child, and to care for such child; the placement of a child with an Employee for adoption; to care for an Employee's seriously ill Spouse, child, or parent; a serious health condition that makes an Employee unable to perform his or her job functions; to tend to necessary arrangements arising out of a Spouse, child, or parent having been called to active military duty (such as making childcare or financial arrangements or attending military events); and to care for a Spouse, child, parent, or nearest blood relative ("next of kin") who is a member of the Armed Forces being treated for, recuperating from, or on the temporary disability retired list due to a serious injury or illness. Health coverage benefits during Your approved leave of absence under The Family and Medical Leave Act, will continue as long as You pay any required contributions. If You choose to not return to work at the end of an approved leave for reasons other than a continued serious health condition, you will be liable for health insurance premiums paid by the City during the time of Family and Medical leave.

The health care coverages provided pursuant to the FMLA under the Plan are the same as would be provided if you had been employed during the leave period. You may choose not to continue health care coverages under the Plan during the FMLA leave, in which case you shall be immediately reinstated to health care coverages under the Plan when you return from the FMLA leave.

FMLA health care benefit coverages shall terminate when:

- you inform the employer of your intent not to return from FMLA leave;
- you fail to return from the FMLA leave; or
- you exhaust your FMLA leave.

Subscribers on FMLA leave are required to continue to pay required contributions, if any, toward coverage during the FMLA leave. If the FMLA leave is substituted by paid leave, contributions may be made by payroll deduction under the Flexible Benefits Plan or by whatever alternative method is normally utilized for making such contributions when the Subscriber is on paid leave. If the FMLA leave is unpaid leave, contributions may be made at the same time as the contribution would be made by payroll deduction. Your failure to pay your share of contributions within thirty (30) days after the due date shall result in termination of coverage, provided the Employer has given you fifteen (15) days advance written notice of the termination of coverage. If coverage ends due to the failure to make timely contributions, you shall be entitled to immediate reinstatement of health care coverages under the Plan on your return from the FMLA leave. Any changes by the Employer to your contributions shall apply while you are on FMLA leave.

Under the law, employees are eligible if they have worked for a covered employer for at least 12 months, and have been in pay status for at least 1,250 hours during the previous 12 months, and if there are at least 50 employees within 75 miles.

It is the employee's responsibility to request leave under the FMLA and to comply with all requests for information, such as medical certifications, made by Your employer. When the need for leave is foreseeable, the employee must provide reasonable prior notice and make efforts to schedule leave so as not to disrupt company operations.

If You have any questions concerning Your rights under the Family and Medical Leave Act, or Your employer's responsibilities under the Act, please contact the Human Resources Department.

Important Notice Regarding Termination of Medicaid or CHIP Coverage

Subject to the conditions set forth below, an employee who is eligible but not enrolled, or the Dependents of such Eligible Employee, if eligible but not enrolled, may enroll in this Plan if either of the following two conditions are satisfied.

Termination of Medicaid or CHIP Coverage. The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act, or under the State Children's Health Insurance Program ("SCHIP") under Title XXI of the Social Security Act, and coverage of the Eligible Employee or Dependent under either the Medicaid or SCHIP plan is terminated as a result of loss of eligibility under such plan.

Eligibility for Employment Assistance Under Medicaid or SCHIP. The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent becomes eligible for premium or other assistance with respect to coverage under this Plan, pursuant to a Medicaid plan or SCHIP plan (including any waiver or demonstration product conducted under or related to such Medicaid or SCHIP plan).

Required Length of Special Enrollment Notification. An Eligible Employee and/or his or her Dependents must request special enrollment in writing no later than sixty (60) days from the date of termination of the Medicaid/SCHIP eligibility or the date the Eligible Employee or Dependent is determined to be eligible for the premium assistance.

Effective Date of Coverage. Coverage shall become effective on the first day of the month following the month in which the Plan received the request for Special Enrollment.

Governmental Exception to Mental Health Parity

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local government employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. City of Wichita has elected to exempt City of Wichita Health Plans from the following requirements:

Parity in the application of certain limits to mental health benefits. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

The exemption from these Federal requirements will be in effect for the 2015 year) beginning Jan. 1, 2015 and ending Dec. 31, 2015. The election may be renewed for subsequent plan years.

COVERED SERVICES

The Plan covers only those services and supplies that are (1) deemed Medically Necessary as well as not considered Experimental or Investigational, (2) Pre-Certified, if Pre-Certification is required, (3) not expressly excluded in the list of Exclusions and Limitations section as set forth in this SPD, and (4) incurred while the Member is eligible for Coverage under the Plan. It is the Member's responsibility to verify whether a Covered Service requires Pre-Certification and should always reference the Schedule of Pre-Certification Requirements prior to receiving Covered Services. A Member should not assume that a Participating Provider has already accomplished the Pre-Certification.

The following section, **Covered Services**, provides the services and supplies Covered. The schedule is provided to assist You with determining the level of Coverage, limitations, and exclusions that apply for Covered Services when determined to be Medically Necessary, subject to the **Exclusions and Limitations** section set forth in this SPD. If a service is not specifically listed and not otherwise excluded, please contact the Plan to confirm whether the service is a Covered Service.

Please note that the Covered Services in the schedule below are subject to all applicable Exclusions and Limitations of this SPD.

Covered Services

Abortion is provided for Elective and non-Elective Abortions.

Allergy testing, Diagnosis, treatment, allergy serum (excluding physician services sublingual treatment), and the administration of injections.

Ambulance (air and ground) for Emergency ambulance transportation, when transport by other means is not medically safe, by a licensed ambulance service to the nearest Hospital where Emergency Services can be rendered.

Blepharoplasty when determined Medically Necessary subject to the Plan's guidelines and criteria.

Blood and Blood Products Processing for administration, storage, and processing of blood and blood products in connection with services Covered under the SPD.

Bone Anchored Hearing Aids (BAHAs) or Temporal Bone Stimulators (effective as of January 1, 2016) when determined to be Medically Necessary by the Administrative Services Provider.

Breast Reconstruction for breast Reconstructive Surgery and prosthesis following a Medically Necessary mastectomy resulting from diagnosed cancer. As required by the Women's Health and Cancer Rights Act ("WHCRA"), after a Covered mastectomy, benefits will be provided for augmentation and reduction of the affected breast, augmentation or reduction on the opposite breast to restore symmetry, prosthesis, and treatment of physical complications at all stages of the mastectomy, including lymphedema. This also includes nipple reconstruction.

Breast Reduction (effective as of January 1, 2016) when associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer or when Medically Necessary because breast hypertrophy is causing significant pain, paresthesias, or ulceration; provided that prior authorization is required and that approval shall be limited to women aged eighteen (18) or older or for whom growth is complete (*i.e.*, breast size is stable for over one year). Reduction mammoplasty for asymptomatic members is considered to be a Cosmetic Service or Surgery.

Cardiac Rehabilitation Services, but limited to treatment for conditions that in the judgment of a Provider and the Medical Director are subject to significant improvement of Your condition.

Chemical Dependency Benefits subject to the Schedule of Benefits; for Inpatient treatment in a Hospital or Residential Treatment Facility, including the services of mental health professionals, or through a Medical or Social Setting Detoxification program; and Outpatient treatment, including service provided through a Nonresidential Treatment Program or through partial or full-Day-Program Services.

Chemotherapy for standard chemotherapy, including, but not limited to, dose-intensive chemotherapy for the treatment of breast cancer; subject to the Plan's Experimental and Investigational exclusion.

Child Health Supervision Services for the periodic review of a Dependent child's physical and emotional status by a Physician or pursuant to a Physician's supervision. A review shall include a history, complete physical examination, development assessment, anticipatory guidance, appropriate immunizations and laboratory tests consistent with prevailing standards. Periodic reviews are Covered, at a minimum, from the date of birth through the age of twelve years at the following intervals: birth, two months, four months, six months, nine months, twelve months, eighteen months, two years, and yearly after age two.

Chiropractic Services See the Spinal Manipulations/Chiropractic Services Section.

Cochlear Implantation. Services related to cochlear implantation will be covered when evidence is adequate to conclude that cochlear implantation is reasonable and necessary for the treatment of bilateral pre-or-post linguistic sensorineural, moderate-to-profound hearing loss in covered individuals who demonstrate limited benefit from amplification. Limited benefit from amplification is defined by test scores of <40% correct in the best-aided listening condition on tape-recorded tests of open-set sentence cognition. Covered services will include surgery, the implant cost and all related testing and post-operative treatment services such as training and adjustments, subject to review for ongoing necessity. Coverage is limited to one implantation per ear, per Lifetime.

Clinical Trials for those costs incurred for drugs and devices that have been approved for sale by the FDA, regardless of whether approved by the FDA for use in treating the Member's particular condition, including Coverage for Medically Necessary services needed to administer the drug or use the device under evaluation in the clinical trial.

Colorectal Cancer Screening for a colorectal cancer exam and related laboratory testing for any asymptomatic Member pursuant to the Plan's criteria, which are in accordance with the current American Cancer Society and U.S. Preventive Services Taskforce guidelines.

Contraceptive Devices for contraceptive implants, diaphragms, and IUDs (including their insertion and removal), as specifically provided in the Schedule of Benefits. Contraceptive supplies and devices obtained at a pharmacy are only covered through a pharmacy Rider.

Dental Services for the removal of tumors and cysts of the jaws, lips, cheeks, tongue, roof and floor of the mouth, and removal of bony growths of the jaw, soft and hard palate; non-surgical treatment of Myofascial Pain Syndrome (MPDS) and Temporomandibular Joint Dysfunction Syndrome (TMJ), including initial diagnostic examination and x-rays, follow-up office visits, and appliances (night guards and bite plates); acute trauma of sound, natural teeth caused directly by an accidental injury (not from biting or chewing) within a twelve (12) month consecutive time period from the date of injury; removal of bony impacted wisdom teeth; and x-rays when required in connection with Covered oral surgery.

There shall also be Coverage for the administration of general anesthesia and Hospital charges for dental care provided to the following Members:

(1) A Dependent child age of five and under;

A Member who is severely disabled; or

A Member who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

The Coverage for the administration of general anesthesia and Hospital charges must be provided regardless of whether the dental services are provided in a Hospital, surgical center or office.

Dermatological Services for the necessary removal of a skin lesion that interferes with normal body functions or is suspected to be malignant.

Dialysis for hemodialysis and peritoneal services provided by outpatient or inpatient facilities or at home. For home dialysis, equipment, supplies, and maintenance will be a Covered Service.

Durable Medical Equipment (“DME”) when determined to be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body member; rental or purchase at the discretion of the Plan. Upgrades to equipment are the responsibility of the Member.

Emergency Services for health services and supplies furnished or required to screen and stabilize an Emergency Medical Condition provided on an outpatient basis at either a Hospital or an Alternate Facility. You should notify Your Physician and the Plan within 48 hours of admission or the next business day or as soon as physically able. The determination of Covered Services for services rendered in an emergency facility is based on the prudent layperson standard, along with those relevant symptoms and circumstances that preceded the provision of care.

If Medically Necessary follow-up care related to the initial Emergency Medical Condition service is required, you should contact and coordinate with Your Physician.

Enteral Nutrition (tube feeding) only when the following criteria are met, not including enteral products which can be administered orally or those that can be purchased over-the-counter.

(1) The medical records indicate the Member’s medical condition has existed longer than three months; and

(2) The Member’s medical condition prevents food from reaching the intestines or prevents absorption of food in the intestines; and

(3) The condition requires tube feedings to provide sufficient nutrients to maintain weight and strength. Adequate nutrients must not be possible by dietary adjustment and/or oral supplements.

Eye Glasses and Corrective Lenses for the first pair of eyeglasses or corrective lenses following cataract surgery; or one pair of contact lenses or one pair of sclera shells intended for use as corneal bandages or for medically-diagnosed eye diseases approved by the Plan Medical Director.

Genetic Counseling and genetic studies only when required for Diagnosis or treatment of genetic abnormalities where historical evidence suggests a potential for such abnormalities and the testing will alter the outcome of treatment.

Growth Hormone therapy for Dependent children less than 18 years of age, who meet the criteria for coverage and who have been appropriately diagnosed to have an actual growth hormone deficiency according to clinical guidelines used by the Plan.

Gynecological Examinations for well-woman examinations, including services, supplies and related tests by an obstetrician, gynecologist or obstetrician/gynecologist, in accordance with the current American Cancer Society and the U.S. Preventive Services Taskforce Guidelines.

Hearing Screenings for a hearing screening to determine hearing loss.

Home Health Care Services when all of the following requirements are met:

- (1) the service is ordered by a Physician;
- (2) services required are of a type which can only be performed by a licensed nurse, physical therapist, speech therapist, respiratory therapist, or occupational therapist;
- (3) part-time intermittent services are required;
- (4) a treatment plan has been established and periodically reviewed by the ordering Physician; and
- (5) the agency rendering services is licensed by the State of location.

Hospice rendered by a Provider for treatment of a terminally ill Member when ordered by a Physician. Care through a hospice program includes supportive care involving the evaluation of the emotional, social and environmental circumstances related to or resulting from the Illness, and guidance and assistance during the Illness for the purpose of preparing the Member and the Member's family for a terminal Illness.

Infertility for office visits, labs, sonograms, diagnostic studies and certain surgical procedures specifically surgical correction of physiological abnormalities causing Infertility, which are related to diagnosing and treatment of Infertility when listed in the Schedule of Benefits. *See Prescription Drug.*

Inpatient Hospital Care including Semi-Private Accommodations and associated professional and ancillary services. Certain services rendered during a Member's Confinement may be subject to separate benefit restrictions and/or Copayments as described in the Schedule of Benefits and Schedule of Exclusions.

Laboratory and Pathology Services

Maternity Services are treated as any other Illness; including the birth mother's delivery expenses of a Child adopted by a Member within ninety (90) days of such Child's birth, which shall be subject to the limitations and exclusions of this Agreement. Coverage includes mother and her newborn child for forty-eight (48) hours of post-natal maternity care for vaginal delivery and ninety-six (96) hours of post-natal maternity care for cesarean delivery. The Plan may authorize a shorter Hospital stay if the attending Provider, after consulting with the mother, approves discharging earlier than 48 hours (or 96 hours as applicable). The discharge shall be made in accordance with the most current version of the "Guidelines for Perinatal Care", or similar guidelines; and the Plan shall provide post-discharge care consisting of two visits by a registered professional nurse. The location and schedule of the post-discharge visits shall be determined by the attending physician who has approved the early discharge. Inpatient Hospital services may be subject to Member responsibility as defined in the Schedule of Benefits.

Mental Health Benefits subject to the Schedule of Benefits; for Inpatient treatment in a Hospital or Residential Treatment Facility, including the services of mental health professionals; and Outpatient treatment, including treatment through a partial or full-Day Program Services. The Plan contracts with an outside vendor to coordinate and determine Medical Necessity of the Diagnosis and treatment of all biologically based Mental Illnesses, psychiatric conditions, and Substance Abuse (“Mental Health and Substance Abuse”). If You have any questions about Your Mental Health and Substance Abuse Coverage, the appropriate way to access Coverage, or to Pre-Certify care for Mental Health and Substance Abuse, you must contact the contracted vendor. The vendor’s name and telephone number are listed on the back of Your ID card and on the Additional Information section following this SPD.

Newborn Care for eligible newborn children for Injury or Illness, Reconstructive Surgery for the treatment of medically diagnosed congenital defects or birth abnormalities; screening for phenylketonuria (“PKU”) and such other common metabolic or genetic diseases; and newborn Hearing Screening examinations, any necessary re-screening, audiological assessment and any requisite follow-up.

Nutritional Counseling when provided by a registered dietician and when the Member is diagnosed with diabetes.

Oral Surgery and Diseases of the Mouth for diseases of the mouth, unless the condition is due to dental disease or of dental origin, limited to the reduction or manipulation of fractures of facial bones; excision of lesions of the mandible, mouth, lip, or tongue; incision of accessory sinuses, mouth, salivary glands, or ducts; reconstruction or repair of the mouth or lip necessary to correct anatomical functional impairment caused by congenital defect.

Orthotic Devices for the initial purchase of Orthotic Appliances following the onset or initial Diagnosis of the condition for which the device is required, including splints and braces, necessary adjustments to shoes to accommodate braces. Shoe inserts and orthopedic shoes will be Covered only if the Member has diabetes with demonstrated peripheral neuropathy OR the insert is needed for a shoe that is part of a brace; orthopedic shoes are limited to one pair per Calendar year.

Osteoporosis related to Diagnosis, including central bone density test; Medically Necessary treatment and appropriate management of osteoporosis. In determining medical appropriateness, due consideration shall be given to Peer-Review Medical Literature.

Outpatient Diagnostic Services and supplies for outpatient diagnostic services provided under the direction of a Provider at a Hospital or Alternate Facility; testing pregnant women and children for lead poisoning shall be covered as any other outpatient diagnostic service; and human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing for A, B, and DR antigens.

Outpatient Surgery provided under the direction of a Provider at a Hospital or Alternate Facility.

Outpatient Therapy Services for short-term outpatient therapy services that are expected to result in significant functional improvement of the Member's condition or as related to a pervasive disorder, including Autistic, Rett’s, Asperger’s or Childhood Disintegrative Disorder; limited to physical therapy, occupational therapy, and speech therapy. Speech therapy is covered for loss or impairment of speech or hearing. The phrase “loss or impairment of speech or hearing” shall include those communicative disorders generally treated by a speech pathologist, audiologist or speech/language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both and which fall within the scope of his/her license or certification.

PKU or any other Amino and Organic Acid Inherited Disease Formula/Food for formula and/or food used for PKU or any other amino and organic acid inherited disease that is recommended by a Provider as determined by the Plan to be Medically Necessary.

Physician Services including but not limited to, office visits, Hospital visits, consultations, and interpretation of tests.

Podiatry Services is provided for Physician visits and certain outpatient surgeries.

Preventive Services for wellness benefits including:

- Immunizations (except those required for travel or employment) as recommended by the American Academy of Pediatrics or other nationally recognized health care agency. Covered Services for routine and necessary immunizations for Dependent children from birth up to 72 months shall be provided at 100% of the allowable charge and will not be subject to any Copayment requirements. Adult immunizations are Covered as per guidelines of the Center for Disease Control and Prevention (“CDC”) and the U.S. Preventive Services Taskforce Guidelines. Any office visit charges incurred, in conjunction with these immunizations will be subject to the Deductible, Copayment or Coinsurance as listed in the Schedule of Benefits;
- Well child care;
- Flu shots;
- Cholesterol screening;
- Coronary artery disease risk screening, such as routine laboratory tests, physical examination, and routine EKG;
- Blood pressure screening;
- Colorectal examinations;
- Fecal occult blood screening;
- Routine annual Gynecological Examination and Pap Smear;
- One (1) mammogram per Calendar Year or more frequently if ordered by a Physician; and
- Both a prostate-specific antigen blood test and a digital rectal exam for men 40 years of age or older who are symptomatic or in a high-risk category and for all men 50 years of age or older.

Prosthetic Devices for the initial purchase of Prosthetic Devices following the onset or initial Diagnosis of the condition for which the device is required. For Prosthetic Device placements requiring a temporary and then a permanent placement only one (1) temporary device will be Covered. Coverage is provided for Prosthetic Devices, including but not limited to, purchase of artificial limbs, breasts, and eyes, which meet the minimum requirements or specifications which are Medically Necessary for treatment, limited to the basic functional device which will restore the lost body function or part. Coverage is provided for external Prosthetic Devices that are used in lieu of surgery for breast reconstruction due to a mastectomy.

Replacement of Prosthetic Devices, which become non-functional and non-repairable due to: (1) A change in the physiological condition of the Member; (2) Irreparable wear or deterioration from day-to-day usage

over time of the device; or (3) The condition of the device requires repairs and the cost of such repairs would be greater than the cost of a replacement device.

Prosthetics will be replaced for documented growth in a Dependent child requiring replacement.

Polishing and resurfacing of eye prosthetics are Covered on a yearly basis.

Coverage for Prosthetic devices will be subject to the benefit limit as expressed in the Schedule of Benefits. Coverage for internal Prosthetic Devices, including but not limited to, artificial heart valves, artificial joint appliances, orthopedic implants, will not be subject to the benefit limit.

Pulmonary Rehabilitation Services, but limited to treatment for conditions that in the judgment of a Provider and the Medical Director are subject to significant improvement of Your condition through relatively short-term therapy.

Radiation Therapy for standard radiation therapy.

Radiology as determined by the Plan.

Reconstructive Surgery are limited to the surgical correction of congenital birth defects only for newly born Member, or the effects of disease or Injury, which cause anatomical functional impairment, when such surgery is reasonably expected to correct the functional impairment.

Rehabilitation Services and Supplies for short-term inpatient or outpatient rehabilitation services which are expected to result in significant functional improvement of the Member's condition. Rehabilitation services must be performed by a Provider, including a free standing rehabilitation facility.

Sleep Studies unless provided within the home and subject to the Plan's Limitations and Exclusions.

Skilled Nursing Facility Services for Confinement (on a Semi-Private Accommodations basis) and medical services and supplies provided under the direction of a Provider in a Skilled Nursing Facility for the care and treatment of an Injury or Illness which cannot be safely provided in an outpatient setting, as determined by the Plan. Certain ancillary services rendered during a Member's Confinement are subject to separate benefit restrictions and/or Member responsibilities as described elsewhere in this SPD or in the Schedule of Benefits.

Spinal Manipulations / Chiropractic Services when they are delivered by a duly licensed Provider acting within the scope of his or her license:

- **Initial Examinations**
Coverage includes the initial Diagnosis and clinically appropriate and Medically Necessary services and supplies required to treat the diagnosed disorder. This examination is performed to determine the nature of the Member's problem. Examinations should be limited to the portion of the body in which the symptoms are being experienced. A more thorough examination of the bodily systems may be done if appropriate clinical indications are present and documented. Vital signs should be included in examinations when appropriate.
- **Subsequent Office Visits**
This may include an adjustment, a brief examination and other Medically Necessary services.

- **Re-examination**
This is performed to assess the need to continue, extend, or change the course of treatment. A re-evaluation may be performed during a subsequent office visit.

Sterilization (voluntary) except those services and associated expenses related to reversal of voluntary sterilization.

Therapeutic Injections and IV Infusions for Injectable and Self-Injectable medications when FDA-approved, medically appropriate subject to the Plan's formulary list and substitute Coverage by therapeutically interchangeable drugs, according to clinical guidelines used by the Plan. *See Express Script SPD.*

Transplants when approved by the Plan, performed at a Coventry Transplant Network participating facility and the recipient is a Member.

Donor screening tests are Covered and are subject to a Lifetime benefit maximum of \$10,000 when performed at a Coventry Transplant Network participating facility.

If not Covered by any other source, the cost of any care, including complications up to 90-days, arising from an organ donation by a non-Member when the recipient is a Member will be Covered for the duration of the Agreement of the Member when approved by the Plan.

Coverage shall include the treatment of breast cancer by autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in autologous bone marrow transplants or stem cell transplants.

The cost of any care, including complications, arising from an organ donation by a Member when the recipient is not a Member is excluded.

Transportation if the Member resides more than one hundred-fifty (150) miles from the transplant facility. Travel expenses may include the lodging for one family member or responsible adult. Transportation, lodging and meal costs shall not exceed a maximum benefit of \$2,000 per year.

Urgent Care Services for an unexpected illness or injury that does not qualify as an Emergency Medical Condition but requires prompt medical attention. If possible, please contact Your Physician in the event Urgent Care services are/were rendered. Your Physician is available to provide guidance and direction in situations that may require Urgent Care. However, failure to notify Your Physician will not result in denial of Coverage. If Medically Necessary follow-up care related to the initial Urgent Care service is required, you should contact and coordinate with Your Physician.

Vision Services for eye examinations, other than for the purpose of refraction, when associated with a medical condition; and one (1) routine refraction service every 24 months.

EXCLUSIONS AND LIMITATIONS

The following items are excluded from Coverage:

Acupuncture Services and associated expenses that include, but are not limited to, the treatment of certain painful conditions or for anesthesia purposes are not Covered;

Allergy Services by physician services i.e., sublingual treatment, non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning;

Alternative Therapies including, but not limited to, aquatic, recreational, wilderness, educational, music or sleep therapies and any related diagnostic testing;

Ambulance Service for non-Emergency and non-medically appropriate ambulance services are excluded regardless of who requested the services, including ambulance transport due to the absence of other transportation for the Member;

Augmentative Communication Devices including but not limited to, those used to assist hearing impaired, or physically or developmentally disabled Members;

Autopsy services and associated expenses related to the performance of autopsies to the extent that payment for such services is, by law, Covered by any governmental agency as a primary plan;

Behavior modification

Biofeedback

Blood and Blood Products for the costs of whole blood and blood products replacement to a blood bank;

Blood Storage services and associated expenses related to personal blood storage, unless associated with a scheduled surgery. Additionally, fetal cord blood harvesting and storage is not a Covered service;

Braces and supports needed for athletic participation or employment;

Breast Reduction Surgery unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer. Effective January 1, 2016, **Breast Reduction Surgery** will not be covered unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer or when Medically Necessary because breast hypertrophy is causing significant pain, paresthesias, or ulceration. Reduction mammoplasty for asymptomatic members is considered a Cosmetic Service or Surgery;

Career, Camp, Sports, Education, Travel, Employment, Insurance, Marriage or Adoption Examinations such as physical, psychiatric or psychological examinations or testing, vaccinations, immunizations or treatments including routine immunizations for college, and services relating to judicial or administrative proceedings or orders which are conducted for purposes of medical research or to obtain or maintain a license of any type;

Conduct Disorders including but not limited to Residential Treatment Programs, inpatient and/or outpatient.

Cosmetic Services and Surgery associated expenses, or complications resulting from Cosmetic Surgery, which alters appearance but does not restore or improve impaired physical function;

Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy, anti-social behavior, academic or phase-of-life problems are not Covered Services;

Court-ordered services or services that are a condition of probation or parole;

Custodial Care, domiciliary care, private duty nursing, respite care or rest care. This includes care that assists Members in the Activities of Daily Living like walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets and supervision of medication that is usually self-administered regardless of who orders the services;

Dental Services provided by a Doctor of Dental Surgery, "D.D.S.," a Doctor of Medical Dentistry "D.M.D." or a Physician licensed to perform dental-related oral surgical procedures, including services for overbite or under-bite, services related to surgery for cutting through the lower or upper jaw bone, and services for the diagnostic or surgical treatment of temporomandibular joint disorder ("TMJ"), whether the services are considered to be medical or dental in nature except as provided in the "Covered Services" Section of this SPD. Dental x-rays, supplies and appliances (including occlusal splints and orthodontia). Removal of dentiginous cysts, mandibular tori and odontoid cysts are excluded as they are dental in origin;

Dental Surgery and Implants for upper and lower jaw bone surgery and dental implants (including that related to the temporomandibular and craniomandibular joint). Dental implants are excluded. Removal of teeth as a complication of radionecrosis is not a Covered Service;

Durable Medical Equipment ("DME") limited to electronically controlled cooling compression therapy devices (such as polar ice packs, Ice Man Cool Therapy, or Cryo-cuff); home traction units; photo therapy; replacement for changes due to obesity; preventive or routine maintenance due to normal wear and tear or negligence of items owned by the Member; personal comfort items, including breast pumps, air conditioners, humidifiers and dehumidifiers, even though prescribed by a Physician, unless defined as Covered Services; and equipment or services for use in altering air quality or temperature;

Educational Services for remedial education including, but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders unless treatment is related to pervasive disorder as provided under Covered Services and behavioral training; including, educational testing or psychological testing, unless part of a treatment program for Covered Services; and services rendered or billed by a school or halfway house;

Charges incurred before the **Effective Date** of Coverage.

Elective or Voluntary Enhancement procedures, services, and medications (Growth Hormone and testosterone), including, but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, mental performance, salabrasion, chemosurgery, laser surgery or other skin abrasion procedures associated with the removal of scars, tattoos, or actinic changes. In addition, service performed for the treatment of acne scarring, even when the medical or surgical treatment has been provided by the Plan;

Eligible Expenses that exceed the maximum allowance or benefit limit;

Enteral Feeding Food Supplement for the cost of outpatient enteral tube feedings or formula and supplies except when used for PKU or any other amino and organic acid inherited disease is not Covered, except as defined as a Covered Service;

Exercise equipment, hot tubs and pools;

Experimental or Investigational treatment

Eye Glasses and Contact Lenses incurred in connection with the provision or fitting of eye glasses or contact lenses, except as specifically provided in the Covered Services Section;

Failure to Cancel such as charges resulting from Your failure to appropriately cancel a scheduled appointment;

Food or food supplements;

Foot Care in connection with corns, calluses, flat feet, fallen arches or chronic foot strain. Medical or surgical treatment of onychomycosis (nail fungus) is also excluded, except as specifically provided for a diabetic Member;

Growth Hormone therapy for any condition, except in Dependent children less than 18 years of age who have been appropriately diagnosed to have an actual growth hormone deficiency according to clinical guidelines used by the Plan;

Hair analysis, wigs and hair transplants related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also excluded are hairstyling, hairpieces and hair prostheses, including those ordered by a Provider;

Home services to help meet personal, family, or domestic needs;

Health and Athletic Club Membership costs of enrollment in a health, athletic or similar club;

Hearing Services and Supplies and associated expenses for hearing aids, digital and programmable hearing devices, the examination for prescribing and fitting hearing aids, hearing therapy and any related diagnostic hearing tests;

Household Equipment and Fixtures, purchase or rental of household equipment such as, but not limited to, fitness equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, water purifiers, hypo-allergenic pillows, power assist chairs, mattresses or waterbeds and electronic communication devices;

Hypnotherapy and Hypnosis;

Immunizations for travel, employment or education unless otherwise Covered under the Covered Services Section;

Infertility Treatment Services including non-diagnostic services and associated expenses for the promotion of conception including, but not limited to, artificial insemination, intracytoplasmic sperm injection (“ICSI”), in vitro or in vivo fertilization, gamete intrafallopian transfer (“GIFT”) procedures, zygote intrafallopian transfer (“ZIFT”) procedures, embryo transport, reversal of voluntary sterilization, surrogate parenting, selective reduction, cryo preservation, travel costs, donor eggs or semen and related

costs including collection, preparation and storage, non-Medically Necessary amniocentesis, other forms of assisted reproductive technology and any Infertility treatment deemed Experimental or Investigational.

No legal obligation to pay for services related to Injuries and Illnesses for which the Plan has no legal obligation to pay (e.g., free clinics, free government programs, court-ordered care, expenses for which a voluntary contribution is requested) or for that portion of any charge which would not be made but for the availability of benefits from the Plan, or for work-related injuries and Illness. Health services and supplies furnished under or as part of a study, grant, or research program;

Maintenance Therapy once the maximum therapeutic benefit has been achieved for a given condition, ongoing Maintenance Therapy is not considered Medically Necessary;

Male Gynecomastia and associated expenses for treatment of male gynecomastia.

Massage Therapy and associated expenses related to massage therapy;

Mental Retardation services and disorders after Diagnosis and relating to learning, motor skills, communication, feeding and eating in infancy and early childhood;

Military Health Services for treatment of military service-related disabilities when the Member is legally entitled to other Coverage and for which facilities are reasonably available to the Member; or those services for any otherwise Eligible Employee or Dependent who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act; or services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;

Miscellaneous Service Charges such as telephone consultations, charges for failure to keep a scheduled appointment (unless the scheduled appointment was for a Mental Health service), or any late payment charge;

Myofascial Pain and Temporomandibular Joint (TMJ) Dysfunction Syndromes surgical treatment and correction of; except as defined by Covered Services.

Nutritional-based Therapy except for treatment of PKU and for nutritional deficiencies due to short bowel syndrome and HIV. Oral supplements and/or enteral feedings, either by mouth or by tube, are also excluded;

Newborn home delivery and also the cost of child birth classes;

Non-Covered Services or services that are directly or indirectly a result of receiving a non-Covered Service;

Not Medically Necessary services or supplies

Obesity Services and associated expenses for procedures intended primarily for the treatment of obesity and morbid obesity including, but not limited to, gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw, removal of excess skin, including pannus, and services of a similar nature. Services and associated expenses for weight loss programs, nutritional supplements, dietary counseling, appetite suppressants, and supplies of a similar nature;

Occupational Injury and associated expenses related to the treatment of an occupational Injury or Illness for which the Member is eligible to receive treatment under any Workers' Compensation or occupational disease laws or benefit plans;

Oral Surgery Supplies required as part of an orthodontic treatment program, required for correction of an occlusal defect, encompassing orthognathic or prognathic surgical procedures, or removal of symptomatic bony impacted teeth, other than bony impacted *wisdom* teeth, except as provided under Covered Services;

Orthodontia and related services;

Orthotic Appliances, Repairs or Replacement changes due to obesity; routine maintenance due to normal wear and tear or negligence of items owned by the Member; foot or shoe inserts, arch supports, special orthopedic shoes, heel lifts, heel or sole wedges, heel pads, or insoles whether custom-made or prefabricated;

Services rendered **Outside the Scope of License** of a Participating or Non-Participating Provider;

Over-the-Counter (“OTC”) supplies incidental to outpatient care and Urgent Care Services; ACE wraps, elastic supports, finger splints, Orthotics, and braces; also OTC products not requiring a prescription to be dispensed (e.g., cervical collars and pillows, lumbar-sacral supports, back braces, ankle supports, positioning wedges/pillows, oxygen, medicated soaps, food supplements, and bandages); unless specifically stated as Covered.

Personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies;

Prescription Drugs and Medications Private Duty Nursing services and nursing care on a full-time basis in Your home, or home health aides;

Prosthetic Devices Repairs or Replacement for any otherwise Covered device, including replacement for changes due to obesity.

Prosthetic Devices Repairs or Replacement routine maintenance due to normal wear and tear or negligence of items owned by the Member. **Private inpatient room**, unless Medically Necessary or if a Semi-private room is unavailable;

Relatives, services rendered by a Provider with the same legal residence as a Member, or rendered by a person who is a member of a Member’s family, including Spouse, brother, sister, parent, stop-parent, child or step-child.

Reversal of Sterilization Services - Those services and associated expenses related to reversal of voluntary sterilization;

Sex Transformation Services and associated expenses for sex transformation operations regardless of any Diagnosis of gender role disorientation or psychosexual orientation, including any treatment or studies related to sex transformation. Also excluded is hormonal support for sex transformation;

Sexual Dysfunction including any device, implant or self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasm;

Sleep Studies when provided within the home;

Smoking Cessation

Speech therapy or voice training when prescribed for stuttering or hoarseness;

Sports Related Services or devices used specifically as safety items or to affect performance primarily in sports-related activities, and all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation including braces and orthotics;

Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of a Member acting as a surrogate mother;

Charges incurred after the **Termination Date** of Coverage.

Termination or Refusal of services otherwise Covered related to a specific condition when a Member has refused to comply with, or has elected to terminate the scheduled service or treatment against the advice of a Provider.

Therapeutic devices, support garments, corrective appliances, non-disposable hypodermic needles, syringes, or other devices of any kind, regardless of their intended use, unless otherwise specified Covered elsewhere;

Third Party Liability services for which a third party has liability;

Transplant Organ Removal and associated expenses for removal of an organ for the purposes of transplantation from a donor who is not a Member unless the recipient is a Member and the donor's medical Coverage excludes reimbursement for organ harvesting; Transplant services, screening tests, and any related conditions or complications related to organ donation when a Member is donating organ or tissue to a non-Member;

Transplant Services and associated expenses involving temporary or permanent mechanical or animal organs;

Travel Expenses even though prescribed by a Provider, except as specified in the Covered Services Section;

Treatment for disorders relating to delays in learning, motor skills and communication, including any therapy for developmental delay, unless treatment is related to pervasive disorder as provided under Covered Services.

Vision Aids and associated services for orthoptics or vision training, field charting, eye exercises, blepharoplasty when for cosmetic reasons, radial keratotomy, LASIK and other refractive eye surgery, low vision aids and services or other refractive surgery;

Vocational therapy;

Health services resulting from

War or an Act of War when the Member is outside of the continental United States;

Work hardening programs; and

Workers Compensation health services - Payment for services or supplies for an Illness or Injury eligible for, or Covered by, any Federal, State or local Government Workers' Compensation Act, occupational disease law or other legislation of similar program.

COORDINATION OF BENEFITS

Coordination With Other Plans

This coordination of benefits (“COB”) provision applies when a Member has health care Coverage under more than one plan. “Plan” is defined below. The order of benefit determination rules described herein determine which plan will pay as the Primary Plan. The Primary Plan is the plan that pays first without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all plans do not exceed 100% of the Plan’s total Allowable Expense.

COB Definitions

A “Plan” is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated Coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

“Plan” includes: group insurance, closed panel or other forms of group or group-type Coverage (whether insured or uninsured); Hospital indemnity benefits in excess of \$200 per day; medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts, or premises liability coverage; closed panel or other individual Coverage (except for group-type Coverage), benefits, as permitted by law and subject to the rules on COB with Medicare set forth below.

“Plan” does not include: individual or family insurance, except medical benefits under group or individual automobile contracts; closed panel or other individual Coverage (except for group-type Coverage); amounts of Hospital indemnity insurance of \$200 or less per day; school accident type Coverage, benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and Coverage under other governmental Plans, unless permitted by law.

Each contract for Coverage under this Section is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan. The order of benefit determination rules determine whether the Plan is a “Primary” Plan or “Secondary” Plan when compared to another plan covering You or Your Covered Dependent. When the Plan is Primary, the Plan’s benefits are determined before those of any other plan and without considering any other plan’s benefits. When the Plan is Secondary, the Plan’s benefits are determined after those of another plan and may be reduced because of the Primary Plan’s payments.

“Allowable Expense” means a health care service or expense that is Covered, at least in part by any of the plans covering You or Your Covered Dependent. When a plan provides benefits in the form of service (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not Covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are not the Plan’s Allowable Expenses:

1. If a Member is Confined in a private Hospital room, the difference between the costs of a Semi-private room in the Hospital and the private room, (unless the Member’s stay in a private Hospital room is otherwise a Covered benefit).
2. Dental care, vision care, prescription drugs and hearing aids (whether or not any of these services are Covered).

3. If a Member is Covered by two (2) or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees.
4. The amount a benefit is reduced by the Primary Plan because a Member does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred Provider arrangements.
5. If a Member is Covered by one (1) Plan, which is secondary and calculates its benefits or services on the basis of usual and customary fees, and another Plan, which is primary and provides its benefits or services on the basis of negotiated fees, the lower of the two (2) plans' Allowable shall be the Allowable Expense for all Plans.

“Claim Determination Period” means a Calendar Year. However, it does not include any part of a year during which a Member has no Coverage under the Plan or before the date this COB provision or a similar provision takes effect.

“Closed Panel Plan” is a plan that provides health benefits to Members primarily in the form of services through a panel of Providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other Providers, except in cases of Emergency or referral by a panel member.

“Custodial Parent” means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one-half of the Calendar Year without regard to any temporary visitation.

“Joint Custody”. If the specific terms of a court decree state that the parents shall share joint custody without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules.

Order of Benefit Determination Rules

When two (2) or more plans pay benefits, the rules for determining the order of payment are as follows:

1. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.
2. A Plan that does not contain a COB provision that is consistent with this provision is always Primary. There is one exception: Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary Coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical Coverage's that are superimposed over base Plan Hospital and surgical benefits, and insurance type Coverage's that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
3. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is Secondary to that other plan.
4. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.
 - a) Non-Dependent or Dependent. The plan that covers the Member other than as a dependent, for example as an employee, member, subscriber or retiree is Primary and the plan that covers the Member as a dependent is Secondary. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the plan covering the Member as a dependent; and Primary to the plan covering the Member as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the

Member as an employee, member, subscriber or retiree is Secondary and the other plan is Primary.

- b) Child Covered Under More Than One (1) Plan. The order of benefits when a child is Covered by more than one (1) plan is:
 - i. The Primary Plan is the plan of the parent whose birthday is earlier in the year if:
 - (a) The parents are married;
 - (b) The parents are not separated (whether or not they ever have been married); or
 - (c) A court decree awards joint custody without specifying that one (1) party has the responsibility to provide health care Coverage.
 - ii. If both parents have the same birthday, the plan that Covered either of the parents longer is Primary.
 - iii. If the specific terms of a court decree state that one (1) of the parents is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of those terms, that plan is Primary. This rule applies to Claim Determination Periods or plan years commencing after the plan is given notice of the court decree.
 - iv. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
 - (a) The plan of the Custodial Parent;
 - (b) The plan of the Spouse of the Custodial Parent;
 - (c) The plan of the non-custodial parent; and then
 - (d) The plan of the Spouse of the non-custodial parent.
- c) Active or inactive employee. The plan that covers a Member as an employee who is neither laid off nor retired, is Primary. The same would hold true if a Member is a Dependent of a person Covered as a Retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- d) Continuation Coverage. If a Member whose Coverage is provided under a right of continuation provided by federal or state law also is Covered under another plan, the plan covering the Member as an employee, member, subscriber or retiree (or as that Member's dependent) is Primary, and the continuation Coverage is Secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- e) Longer or shorter length of Coverage. The plan that Covered the Member as an employee, member, subscriber or retiree longer is Primary.
- f) If the preceding rules do not determine the Primary Plan, the Allowable Expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, the Plan will not pay more than the Plan would have paid had the Plan been Primary.
- g) The benefits under this Plan are secondary to any coverage under automobile no-fault medical benefits coverage under group or individual automobile contracts, premises liability coverage, or similar coverage.

Effect On The Benefits of the Plan

When the Plan is Secondary, the Plan shall reduce the Plan's benefits so that the total benefits paid or provided by all plans during a Claim Determination Period are not more than 100% of total Allowable Expenses.

If a Member is enrolled in two (2) or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one (1) Closed Panel Plan, COB shall not apply between that plan and other Closed Panel Plans.

Coordination of Benefits with Medicare

Active Employees and Spouses Age 65 and Older

- a) If an employee is eligible for Medicare and works for an employer with fewer than twenty (20) employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding Calendar Year, then Medicare will be the primary payer. Medicare will pay its benefits first. The Plan will pay benefits on a secondary basis.
- b) If an employee works for an employer with more than twenty (20) employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding the Calendar Year, the Plan will be primary. However, an employee may decline Coverage under the Plan and elect Medicare as primary. In this instance, the Plan, by law, cannot pay benefits secondary to Medicare for Medicare -Covered services.

You will continue to be Covered by the Plan as primary unless You (a) notify the Plan, in writing, that You do not want benefits under the Plan, or (b) otherwise cease to be eligible for benefits under the Plan, or (c) if we determine through some other means that we are not the primary carrier.

Retired Employees and Spouses

If you, as a Retiree, or your Dependent(s) covered by the Plan, become eligible for Medicare **before attainment of age 65**, you should enroll in Medicare coverage when it is first made available. The Medicare eligible individual can remain in the City's Plan, subject to enrollment qualifications, until age 65. When a Retiree, or their Dependent(s), becomes Medicare eligible, the City's Plan will revert to secondary coverage, with Medicare becoming the primary coverage.

Failure to enroll in Medicare, in the event that you, or your Dependent(s), become eligible prior to age 65, will expose you to payment of all medical claims as a primary payer. As explained above in the active employee provision, City coverage will revert to secondary coverage.

Disability

- a) If You are under age 65 and eligible for Medicare due to disability, and actively work for an employer with fewer than one-hundred (100) employees, then Medicare is the primary payer. The Plan will pay benefits on a secondary basis.
- b) If You are age 65 or older and actively work for an employer with at least one-hundred (100) employees and You become entitled to benefits under Medicare due to disability (other than ESRD as discussed below) the Plan will be primary for You and Your eligible Dependents and Medicare will pay benefits on a secondary basis.

End Stage Renal Disease (“ESRD”)

- a) If You are entitled to Medicare due to End Stage Renal Disease (“ESRD”), the Plan will be primary for the first thirty (30) months. If the Plan is currently paying benefits as secondary, the Plan will remain secondary upon Your entitlement to Medicare due to ESRD.

Right to Receive and Release Needed Information

By accepting Coverage under this Agreement You agree to:

1. Provide the Plan with information about other coverage and promptly notify the Plan of any Coverage changes;
2. Give the Plan the right to obtain information as needed from others to coordinate benefits;

Facility of Payment

A payment made under another plan may include an amount that should have been paid under the Agreement. If it does, the Plan may pay the amount to the organization that made the payment. The amount will then be treated as though it was a benefit paid under the Agreement. The Plan will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payment made by the Plan, including the reasonable cash value of any benefits provided in the form of services, is more than it should have paid under the terms of the Agreement, the Plan may recover the excess payments from one (1) or more of:

1. The persons it has paid;
2. For whom it has paid;
3. Insurance companies; and
4. Other organizations.

SUBROGATION

A Member may incur medical or other expenses resulting from injuries or illness that may be caused by an act or omission which give rise to a claim against a third party or against any person or entity. Such a claim for benefits may be excluded from coverage or the benefits may be coordinated with another plan under the terms of this Plan.

This Plan also does not provide benefits to the extent that there is other coverage under, including, but not limited to any liability insurance, homeowner's plan, no-fault auto coverage, uninsured or underinsured motorist or other insurance policy or funds. However, the Plan may, at its discretion, advance benefits, otherwise payable under this Plan, to or on behalf of said Member only on the following terms and conditions:

In the event that benefits are advanced under this Plan, the Plan shall be subrogated to all rights of recovery that the Member, his heirs, guardians, executors, agents or other representatives may have against any person or organization as a result of or alleged to be as a result of the loss to the extent of the benefits advanced. The Member shall do nothing after loss to prejudice such rights. The Member hereby agrees to cooperate with the Plan and/or any representatives of the Plan in completing such forms and in giving such information surrounding any accident as the Plan or its representatives deem necessary to fully investigate the incident.

The Plan is also granted a right of reimbursement from the proceeds of any monies recovered from any party or insurer whether by settlement, judgment, award or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in the previous paragraph, but only to the extent of the benefits advanced by the Plan. By accepting benefits under the Plan, the Member agrees to reimburse the Plan out of any recovery the Member, or anyone on his or her behalf, might receive from any source, whether by settlement, judgment, award or otherwise.

The Plan, by advancing benefits hereunder, is hereby granted a lien on the proceeds of any settlement, judgment or other payment intended for, payable to, or received by the Member or his/her representatives, and the Member hereby consents to said lien and agrees to take whatever steps are necessary to help the Plan secure said lien. The Member agrees that said lien shall constitute a charge upon the proceeds of any recovery and the Plan shall be entitled to assert security interest thereon. By the acceptance of benefits advanced under the Plan, the Member and his/her representatives agree to hold the proceeds of any settlement in constructive trust for the benefit of the Plan to the extent of 100% of all benefits paid on behalf of the Member. The lien may be enforced against any party or entity that possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Member's representative, agent, trust, estate, and/or any other source possessing funds representing the amount of benefits paid by the Plan.

By accepting benefits hereunder, the Member hereby grants a lien and assigns to the Plan an amount equal to the benefits advanced against any recovery made by or on behalf of the Member. This assignment is binding on any attorney who represents the Member or any insurance company or other financially responsible party against whom the Member may have a claim provided said attorney, insurance carriers or others have been notified by the Plan or its agents.

The subrogation and reimbursement rights and liens apply to any recoveries made by the Member as a result of or alleged to be as a result of the injuries sustained, including but not limited to the following:

- a. Payments made directly by the third party, or any insurance company on behalf of the third party, or any other payments on behalf of the third party.

- b. Any payments or settlements or judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of the Member or other person.
- c. Any other payments from any source designed or intended to compensate the Member for injuries sustained as the result of or alleged to be as a result of negligence or alleged negligence of a third party.
- d. Any worker's compensation award or settlement.
- e. Any recovery made pursuant to no-fault insurance.
- f. Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.

No adult Member hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said Member without the prior express written consent of the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to decedents', minors', incompetent or disabled persons', Members' estates', or any other representative of the Members' recovery rights, settlements or recoveries.

No Member shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude the benefits advanced by the Plan, or anything else that may prejudice the Plan's subrogation or recovery interest of the plan's ability to enforce the terms of this plan provision. The Member agrees to cooperate fully with the Plan's efforts to recover benefits paid. It is the Member's duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Member's intention to pursue or investigate a claim to recover damages or obtain compensation due to the Member's injury, illness or condition. The Member and his/her agent(s) shall provide all information requested by the Plan, the ASP or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the aforementioned requesting entity may reasonably request, and all documents related to or filed in person injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery the Member, or anyone on his or her behalf, receives may result in the termination of health benefits or the institution of court proceedings.

The Member acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

The Member agrees to recognize the Plan's right to reimbursement from the first dollars recovered. The Plan has priority over any and all funds paid by any party to the Member relative to the injuries, including priority over any claim for non-medical or dental charges, attorney fees, or other costs or expenses. This right shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

The Member shall not incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, specifically, no court costs nor attorney's fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine", or "Common Fund Doctrine", or "Attorney's Fund Doctrine".

The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Member, whether under comparative negligence or otherwise, and regardless of whether the settlement or judgment identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is

entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.

The benefits under this Plan are secondary to any coverage under no-fault or similar insurance, including but not limited to automobile medical payments coverage, or premises liability coverage.

In the event that the Member shall fail or refuse to honor his obligations hereunder, then the Plan shall be entitled to recover any costs incurred in enforcing the terms hereof including but not limited to attorney's fees, litigation, court costs, and other expenses. The Plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Member has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

Any reference to state law in any other provision of this policy shall not be applicable to this provision. By acceptance of benefits advanced under the Plan, the Member agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief. The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of the Plan Document.

UTILIZATION REVIEW POLICY AND PROCEDURES

Utilization Review Circumstances

Utilization Review is performed under the following circumstances:

Prospective or Pre-Service Review – Conducting Utilization Review for the purpose of Pre-Certification is called Prospective or Pre-Service Review. Services include, but are not limited to, elective inpatient admission and outpatient surgeries that require Pre-Certification.

Concurrent Care Review – Review that occurs at the time care is rendered. When You are hospitalized or Confined to a Skilled Nursing Facility, concurrent review is conducted on site or by telephone with the Utilization Review department at each facility.

Retrospective or Post-Service Review – Retrospective or post-service review is Utilization Review that takes place for medical services that have not been Pre-Certified by the Plan, after the services have been provided.

Toll Free Telephone Number – The toll free telephone number of the Utilization Review department is listed in the additional information

Timing of Utilization Review Decisions

The time-frame for making Utilization Review decisions is as follows:

Prospective or Pre-Service Review – Two (2) business days from the date that the Plan receives all necessary information. In the event that the Plan does not receive all necessary information in fourteen (14) calendar days after the request for services, a decision will be made based on the information received. In the case of a determination to certify an admission, procedure or service, the Plan shall notify the Provider rendering the service by telephone within twenty-four (24) hours of making the initial certification, and provide written or electronic confirmation of the telephone notification to the Member and the Provider within two (2) working days of making the initial certification;

Concurrent Care Review – Determination regarding an extended stay or additional services will be made within one (1) business day from the date that the Plan receives all necessary information. The service shall be continued without liability to the Member until the Member has been notified of the determination. The Plan shall notify by telephone the Provider rendering the service within one (1) working day of making the determination, and provide written or electronic confirmation to the Member and the Provider within one working day after the telephone notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services;

Retrospective or Post-Service Review – **Thirty (30)** calendar days from the date that the Plan receives the request for determination. The Plan shall provide written notice of determination to the Member within ten (10) working days of making the determination, not to exceed the **thirty (30)** calendar day timeframe.

In the case of an adverse determination for an initial determination and/or concurrent review determination, the Plan shall notify by telephone the Provider rendering the service within twenty-four (24) hours of making the adverse determination, and provide written or electronic

notification to the Member and the Provider within one (1) working day of the telephone notification.

CLAIM PROCEDURES

Claim Timely Filing

If You or a covered Dependent claim benefits, a proof of claim must be furnished to the benefit services manager within 12 months following the date of loss. If a written claim form is not furnished to the claims processor within 12-months, the claim may be denied or reduced. Benefits are based on the Plan's provisions at the time that the charges are incurred. Claims submitted after the 12-month period will not be considered for payment or may be reduced unless it is not reasonably possible to submit the claim in that time, such as the person is not legally capable of submitting the claim. The Administrative Services Provider will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant.

Notice of Benefit Determination

Urgent Care Claims. When the Plan receives a request for Urgent Care that is not an Emergency Service and that satisfies the requirements of the Urgent Care Claims definition, the Plan will notify the Member and/or Authorized Representative of the decision by telephone within one (1) business day and in writing no later than forty-eight (48) hours after the request is received. This notification will be made whether or not there is an Adverse Benefit Determination. If there is insufficient information for the Plan to make a decision, the Administrative Services Provider will notify the Member and/or Authorized Representative no later than twenty-four (24) hours after receiving the request for Urgent Care. The notice will detail the information that is needed to make the decision. The Member and/or Authorized Representative have forty-eight (48) hours to provide the requested information. The Plan will make the decision within forty-eight (48) hours after the earlier of:

- the receipt of the additional information; or
- the end of the forty-eight (48) hour period in which the Member or Authorized Representative has to provide the information.

Pre-Service Claims. When the Plan receives a request for Pre-Certification of a Hospital admission or other service that is not an Urgent Care Claim, the Plan will notify the Member and/or Authorized Representative of the authorization decision, in the case of an Adverse Benefit Determination, no later than two (2) business days after the request and all necessary information are received by the Plan; and, in the case of all other requests, no later than fifteen (15) days after the request and all necessary information are received by the Plan. This notification will be made whether or not there is an Adverse Benefit Determination. If the Plan does not have all the necessary information to make the authorization decision, the Administrative Services Provider will notify the Member and/or Authorized Representative and explain in detail what information is required. The Administrative Services Provider must receive the information requested within forty-five (45) days from the Member's and/or Authorized Representative's receipt of the notice to provide the additional information.

If the Pre-Certification procedures are not followed, the Plan will notify the Member and/or Authorized Representative of the failure to follow the procedures within five (5) days of the request. The notice will include the proper procedures for requesting Pre-Certification.

Post-Service Claims

The Plan will send a notice of an Adverse Benefit Determination (in an Explanation of Benefits) to the Member or Authorized Representative within **thirty (30)** days after the Administrative Services Provider receives the claim for payment. If the Administrative Services Provider does not have the necessary

information to make a payment determination, the Administrative Services Provider will notify the Member or the Authorized Representative of the need for an extension before the end of the initial thirty (30) days. The extension notice will explain in detail what information is required. The Member or Authorized Representative has forty-five (45) days from the receipt of the notice to provide the requested information. The Plan has fifteen (15) days from receipt of the clarifying information or the end of the forty-five (45) day period, whichever is earlier, to make a determination.

Ongoing Treatment. The Plan does not reduce or terminate coverage for care that is Pre-Authorized, as long as the information the Plan was provided to obtain the Pre-Certification is accurate and the Member remains enrolled in the Plan. If the Plan receives a request to extend care beyond what the Plan has Pre-Authorized, the Plan will follow the Urgent Care Claims process above.

Appeal Rights

If an Urgent Care Claim, a Pre-service Claim or a Post-service Claim results in an Adverse Benefit Determination, the Member or Authorized Representative may appeal the decision as described below.

Appeal Process

Throughout the procedures outlined in this Section, if the Member or Authorized Representative fails to file any Appeal within the required timeframes, the Member loses the right to continue the internal appeal process. At any level of appeal, the Member is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the appeal.

The Member has the right, but is not required, to be represented by an attorney during any stage of the Inquiry or Appeal procedures.

In each step of the Inquiry and Appeal procedures, the Member should be as specific as possible as to the remedy sought (e.g., Claim denied - remedy sought is payment).

This Plan has an Appeal process with two levels of review.

A Member or Authorized Representative may file an Appeal by contacting the Customer Services Department at the address and telephone number specified in the Additional Information section following this document. Appeals will be handled by an Appeal Coordinator who may involve other staff of the Administrative Services Provider or Providers. The objective is to review all the facts and to handle the Appeal as quickly and as courteously as possible. If the solution is satisfactory to both the Member and the Plan, the matter ends.

First Level Appeal Process

A Member or Authorized Representative has one hundred eighty (180) days after the Member's receipt of the initial notice of the Adverse Benefit Determination to file an Appeal with the Plan. Requests received after such one hundred eighty (180) day period will not be eligible for the internal Appeal process. The first level Appeal may be submitted in writing or orally. If submitted in writing, it should be sent to the Administrative Services Provider at the address above, Attention: Appeal Process.

Each first level Appeal review includes an investigation of the Appeal and a review by an initial review committee. The committee consists of one or more employees of the Administrative Services Provider who were not involved in initial Adverse Benefit Determination. The Member or Authorized Representative may submit written data or other information for the committee to review.

The Appeal review will be completed and written notification of the decision will be sent to the Member or Authorized Representative within the following time periods:

Pre-Service Appeal – fifteen (15) calendar days after the date on which the Appeal is filed.

Post-Service Appeal – thirty (30) calendar days after the date on which the Appeal is filed.

The written notification will include the basis for the decision and the procedure to request a second level review.

Second Level Appeal Process

A Member has thirty-one (31) days from receipt of the notice of the initial review committee's decision to appeal the decision to the Administrative Services Provider. The Member must submit the appeal in writing to the Administrative Services Provider at the address listed in the Additional Information page following this document.

An appeal of the initial review committee's decision must include all of the following:

- Member's name, address and telephone number;
- Member's Plan identification number;
- Identification of the Plan;
- A brief description of the Appeal; and
- A copy of the decision letter from the review committee.

Each second level Appeal review includes an investigation of the Appeal and a review by a review committee. The committee consists of one or more employees of the Administrative Services Provider who were not involved in the initial Adverse Benefit Determination or the first level Appeal. The Member or Authorized Representative may submit written data or other information for the committee to review.

The second level Appeal review will be completed and written notification of the decision will be sent to the Member or Authorized Representative within the following time periods:

Pre-Service Appeal – **fifteen (15)** calendar days after the date on which the second level Appeal is filed.

Post-Service Appeal – **thirty (30)** calendar days after the date on which the second level Appeal is filed.

The written notification will include the basis for the decision.

Urgent Care Appeal Process.

A Member or Authorized Representative may request an expedited review of an Urgent Care Claim by providing the Plan Sponsor's designee with clinical rationale and facts to support the request. The Urgent Care Appeal hearing will be held within forty-eight (48) hours of the filing of the Urgent Care Appeal and the review will be completed and written notification of the Plan Sponsor designee's decision will be sent to the Member and/or Authorized Representative within seventy-two (72) hours of the filing of the Urgent Care Appeal. A Member is not entitled to further appeal under the Plan's appeal processes after the Plan Sponsor designee's final decision regarding payment for a service that is the subject of an Urgent Care Claim.

Compliance with Regulations. This Plan is a non-ERISA plan. All interpretations, determinations, and decisions of the reviewing entity with respect to any claim will be its sole decision based upon the Plan documents. All decisions of the Plan will be deemed final and binding.

Authorized Representative. A person who is chosen by and identified to assist or authorized to represent the Member, including a family member, Provider, employer representative or attorney. An assignment of benefits by a Member to a health care Provider does not constitute designation of an authorized representative.

Other Important Claims Information. If You or Your representative fail to file a request for review in accordance with the claims procedures as described above, You or Your representative will have no right to review and You or Your representative will have no right to bring an action in any court. The denial of Your claim will become final and binding.

Right to Receive and Release Needed Information. Certain facts are needed to adjudicate claims in accordance with the provisions set forth in the Plan. The Plan has the right to decide which facts are required and may obtain the needed facts from or provide them to any other organization or persons. Each person claiming benefits under this Plan must provide any information required to pay the claim.

HIPAA PRIVACY

This section fulfills the requirements of Section 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations referred to herein as the “HIPAA Privacy Rule” and Section 164.504 (f) is referred to as the “504” provisions) by establishing the extent to which the Plan Sponsor will receive, use and/or disclose Protected Health Information (PHI).

Plan’s Designation of Person/Entity to Act on its Behalf

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates the Human Resources Department to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule (e.g., entering into business associate contracts; accepting certification from the Plan Sponsor).

Definitions

All terms defined in the HIPAA Privacy Rule, shall have the meaning set forth therein. The following additional definitions apply to the provisions set forth herein.

Plan means City of Wichita Group Health Benefits Plan.

Plan Documents mean the Plan’s governing documents and instruments (i.e., the documents under which the Plan was established and is maintained), including but not limited to the City of Wichita Group Benefit Plan Document.

Plan Sponsor means entity or person entrusted with the management of property or with the power to act on behalf of and for the benefit of another.

The Plan’s disclosure of PHI to the Plan Sponsor – Required Certification of Compliance by Plan Sponsor. Except as provided below with respect to the Plan’s disclosure of summary health information, the Plan will (a) disclose PHI to the Plan Sponsor or (b) provide for or permit the disclosure of PHI to the Plan Sponsor with respect to the Plan, only if the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

The Plan Documents establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the “504” provisions;

The Plan Documents have incorporated the Plan provisions set forth in this Section; and

The Plan Sponsor agrees to comply with the Plan provisions as modified in this Section.

Permitted disclosure of individuals' PHI to the Plan Sponsor

- The Plan (and any business associate acting on behalf of the Plan) will disclose individuals’ PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this Agreement.
- All disclosures of the PHI of the Plan’s individuals by the Plan’s business associate to the Plan Sponsor will comply with the restrictions and requirements set forth in this section and in the “504” provisions.
- The Plan (and any business associate acting on behalf of the Plan), may not disclose and may not permit disclosure of individuals’ PHI to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

- The Plan Sponsor will not use or further disclose individuals' PHI other than as described in the Plan Documents and permitted by the "504" provisions.
- The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
- The Plan Sponsor will not use or disclose individuals' PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, of which the Plan Sponsor becomes aware.

Disclosures of individuals' PHI – Disclosure by the Plan Sponsor

- The Plan Sponsor will make the PHI of the individual who is the subject of the PHI available to such individual in accordance with 45 C.F.R. Section 164.524.
- The Plan Sponsor will make individuals' PHI available for amendment and incorporate any amendments to individuals' PHI in accordance with 45 C.F.R. Section 164.526.
- The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' PHI that it must account for in accordance with 45 C.F.R. Section 164.528.
- The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individuals' PHI received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.
- The Plan Sponsor will, if feasible, return or destroy all individuals' PHI received from the Plan that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such PHI after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- The Plan Sponsor will ensure that the required adequate separation between the Plan and the Plan Sponsor is established and maintained.

Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor

- The Plan may disclose summary health information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions, if the Plan Sponsor requests the summary health information for the purpose of:
 - Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
 - Modifying, amending, or terminating the Plan.
- The Plan may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

Required separation between the Plan and the Plan Sponsor

- In accordance with the “504” provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan Sponsor who may be given access to individuals’ PHI received from the Plan.

Benefits Coordinator, Human Resources Department

- The above list reflects the employees, classes of employees, or other workforce members of the Plan Sponsor who receive individuals’ PHI relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to individuals’ PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals’ PHI in violation of, or noncompliance with, the provisions of this document.
- The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

GENERAL PROVISIONS

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between You and the City of Wichita to the effect that You will be employed for any specific period of time. Furthermore, neither the establishment nor maintenance of the Plan nor any Amendment thereof, nor any act or omission under the Plan or resulting from the operation of the Plan shall be construed:

- As conferring upon any Member, beneficiary or any other person a right or claim against the City or the Plan Administrator, except to the extent that such right or claim shall be specifically expressed and provided in the Plan or provided under applicable law;
- As creating any responsibility or liability of the City or Plan Administrator for the validity or effect of the Plan;
- As a contract or agreement between the City and any Member or other person;
- As being consideration for, or an inducement or condition of, employment of any Member or other person, or as affecting or restricting in any manner or to any extent whatsoever the rights or obligations of the City, or any Member or other person to continue or terminate the employment relationship at any time; or
- As giving any Member or other person the right to be retained in the service of the City or to interfere with the right of the City to discharge any Member or other person at any time.

Applicability

The provisions of this document shall apply equally to the Subscriber and Dependents and all benefits and privileges made available to Subscriber shall be available to Subscriber's Dependents.

Exhaustion of Administrative Remedies

A Member may not bring a cause of action hereunder in a court or other governmental tribunal unless and until all administrative remedies set forth in this document have first been exhausted.

Nontransferable

No person other than a Member is entitled to receive health care service coverage or other benefits to be furnished by Plan. Such right to health care service coverage or other benefits is not transferable.

Reservations and Alternatives

The Plan and the Administrative Services Provider reserve the right to contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein.

Severability

In the event that any provision of this document is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this document, which shall continue in full force and effect in accordance with its remaining terms.

Waiver

The failure of the Administrative Services Provider, the Plan Sponsor, or a Member to enforce any provision of this document shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this document shall not be deemed or construed to be a waiver of such default.

Plan Administration

The City shall be the Plan Administrator. Except as otherwise specifically provided in the Plan, the Plan Administrator shall have full, discretionary authority to control and manage the operation and administration of the Plan, and shall be the named fiduciary of the Plan. The Plan Administrator shall have all power necessary or convenient to enable the Plan Administrator to exercise such authority. The Plan Administrator or its designee may provide rules and regulations, not inconsistent with the provisions hereof, for the operation and management of the Plan, and may from time to time amend or rescind such rules or regulations. The Plan Administrator shall have the full discretion, power, and the duty to take all action necessary or proper to carry out the duties required under the Act. The Plan Administrator is authorized to accept service of legal process for the Plan. The Plan Administrator may appoint a carrier, person, entity or corporation to provide consulting services to the Plan Administrator in connection with the operation of the Plan, and it may perform such other functions and services, including the processing and payment of claims, as may be delegated to it by the Plan Administrator. The Plan Administrator has delegated its discretionary authority as indicated under Power and Authority of Administrative Services Provider.

The Plan Administrator may also designate another person or persons to carry out any fiduciary responsibility of the Plan Administrator under the Plan. Any such individual, subcommittee, or organization shall perform the delegated functions until removal by the Plan Administrator, which removal may be without cause and without advance notice. The Plan Administrator shall not be liable for any act or omission of such person in carrying out such responsibility, except as may be otherwise provided under applicable law. To the extent permitted under applicable law, no fiduciary of the Plan shall be liable for any act or omission in carrying out the fiduciary's responsibilities under the Plan. To the extent permitted under applicable law, each fiduciary under the Plan shall be responsible only for the specific duties assigned under the Plan and shall not be directly or indirectly responsible for the duties assigned to another fiduciary.

The Plan Administrator shall be the sole judge of the standards of proof required in any case. In the application and interpretation of this Plan document, the decisions of the Plan Administrator shall be final and binding on the Members and all other persons. Subject to the stated purposes and provisions of this Plan document, the Plan Administrator shall have the full and exclusive power and authority, in its sole discretion, to determine all questions of coverage and eligibility for benefits, methods of providing or arranging for benefits and all other related matters. The Plan Administrator shall have the full power and authority, in its sole discretion, to construe and interpret the provisions and terms of this Plan document and all other written documents including but not limited to any provisions of the Plan relating to subrogation. Any such determination and any such construction adopted by the Plan Administrator in good faith shall be binding upon all of the parties hereto and the beneficiaries thereof and may not be reversed by a court of competent jurisdiction unless the court finds the determination to be arbitrary and capricious. Benefits under the Plan shall be paid only if the Plan Administrator decides in its discretion that the Member is entitled to such benefits under the Plan.

Power and Authority of Administrative Services Provider

The Administrative Services Provider is responsible for (1) determination of the amount of any benefits payable under the Plan, and (2) prescribing claims procedures to be followed and the claim forms to be used. The adjudication of Covered Services, claims, and appeals has been delegated to Coventry Health Care of Kansas, Inc., the Administrative Services Provider. The Plan Administrator is ultimately responsible for providing Plan benefits and interpreting all Plan provisions, other than those benefits services identified in (1) and (2).

Questions

If a Member has any general questions regarding the Plan, please contact the Human Resources Department.

Amendment or Termination

The Plan Sponsor has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the Plan Sponsor or any of its delegates. No change in this document shall be valid unless approved by an officer of Plan Sponsor, and evidenced by endorsement on this document and/or by Amendment to this document. Such Amendment will be incorporated into this document.

Counterparts

The Plan may be executed in any number of counterparts, each of which shall be deemed to be an original. All counterparts shall constitute but one and the same instrument and shall be evidenced by any one counterpart.

Notices

Any notice given under the Plan shall be sufficient if given to the Plan Administrator, when addressed to it at its office; or if given to a Member, when addressed to the Member at his or her address as it appears on the records of the Plan Administrator.

Employment of Consultants

The Plan Administrator, or fiduciary named by the Plan Administrator pursuant to the Plan, may employ one or more persons to render advice with regard to their respective responsibilities under the Plan.

Legal Counsel

The City and/or its designee may from time to time consult with counsel, who may be counsel for the City, and shall be fully protected in acting upon the advice of such counsel.

Evidence of Action

Any action by the City pursuant to any of the provisions of the Plan shall be evidenced by resolution of its governing body, and the Plan shall be fully protected in acting in accordance with such resolution so certified to it. All orders, requests, and instructions by an Employee to the Plan Administrator, the City, the ASP, or any duly authorized representative of the foregoing shall be in writing and such individuals and entities shall act and shall be fully protected in acting in accordance with such orders, requests, and instructions. The Plan, Plan Administrator, the ASP, the City, or any duly authorized representative of the foregoing shall not incur any liability in acting upon any notice, request, signed letter, telegram, or other paper or document believed by the Plan, Plan Administrator, the ASP, or the City to be genuine or to be executed or sent by an authorized person.

Receipt and Release

Any payments to any Member shall, to the extent thereof, be in full satisfaction of the claim of such Member being paid thereby and the Plan, the Plan Administrator, or the City may condition payment thereof on the delivery by the Member of the duly executed receipt and release in such form as may be determined by the Plan, the Plan Administrator, or the City.

Misrepresentation

Any material misrepresentation on the part of the Member in making application for coverage, or reclassification of coverage, or in applying for and/or obtaining benefits under the Plan, shall render the coverage null and void.

Disclaimer of Liability

Nothing contained herein shall confer upon a Member any claim, right, or cause of action, either at law or at equity, against the Plan, Plan Administrator, the ASP, or the City for the acts or omissions of any health care Provider from whom a Member receives care, services, or supplies under the Plan.

Entire Plan

This Plan document shall constitute the only legally governing documents for the Plan. All statements made by the City, Plan Administrator, or ASP shall be deemed representations and not warranties. No such statement shall void or reduce coverage under the Plan or be used in defense to a claim unless in writing signed by the Plan Administrator or its designee. In the event that there may be a discrepancy between any other communication provided to Members regarding the Plan and this Plan document, the Plan document will prevail.

Costs and Expenses

If the Plan Administrator or the City is made a party to any legal action regarding the Plan, except for a breach of fiduciary responsibility of such person or persons, any and all costs and expenses, including reasonable attorneys' fees, incurred by the Plan Administrator or the City in connection with such proceeding shall be paid from the assets of the Plan unless paid by the Plan Administrator or the City.

Entry and Withdrawal of Employers

Any employer approved by the City or its designee as an employer may become a party to the Plan and adopt the Plan for its Eligible Employees as of the first day of any Plan Year, or such other date specified by the City or its designee by delivering to the Plan Administrator an appropriate resolution authorized by the governing board of such organization. With the consent of the City or its designee, such organization shall become an employer hereunder, as of the specified date, and shall be subject to the terms and provisions of the Plan then in effect and thereafter amended. Any such employer may withdraw from the Plan by delivering to the City or its designee a resolution by its governing body authorizing its withdrawal as an employer hereunder. Notice of withdrawal must be submitted to the City or its designee at least thirty (30) days prior to the date withdrawal is to be effective, unless such requirement is waived by the City or its designee.

ADDITIONAL INFORMATION

The information attached herein to this Section is not provided through the self-funded City of Wichita Group Benefit Plan, but has been included within this document as a convenience to the Member. This information is subject to change without notice or Amendment.

Important Telephone Numbers and Addresses

<p>HIPAA Privacy Officer Lisa Hilyard, Benefits Coordinator Department of Human Resources City of Wichita 455 N. Main Street, Wichita, KS 67202</p> <p>(316) 268-4721</p>	<p>COBRA Administrator ASI COBRA P.O. Box 657 Columbia, MO 65205</p> <p>(877) 388-8331</p>
<p>Customer Service / Claims/Utilization Coventry Health Care of Kansas Customer Service PO Box 7109 London, KY 40742</p> <p>(866) 611-7337 (866) 285-1864 TDD</p> <p>http://www.chckansas.com/</p>	<p>Pre-Certification Coventry Health Care of Kansas Customer Service PO Box 7109 London, KY 40742</p> <p>(866) 611-7337 (866) 285-1864 TDD</p>
<p>Appeals and Grievance Coventry Health Care of Kansas Attn: Appeals Department 9401 Indian Creek Parkway, Ste. 1300 Overland Park, KS 66210</p>	<p>Mental Health & Chemical Dependency Vendor MH Net Behavioral Health PO Box 209010 Austin, TX 78720 (866) 607-5970</p>
<p>Vision Service Plan Insurance Company</p> <p>3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195</p>	

2015 PRE-CERTIFICATION LIST

Listed here are procedures that require pre-certification from Coventry Health Care prior to services being performed. Please call Coventry's Health Services department at 816-460-4670, or toll-free at 877-837-8914 with any questions.

Benefit limitations for cosmetic, dental and Infertility still apply. If you have questions about benefits please call the Customer Service phone number on the back of your ID card.

- Inpatient Hospital Admissions /Observation stays/ LTAC
- Skilled nursing admissions
- Chemotherapy Herceptin; Avastin
- Clinical Trials
- Durable medical equipment purchase over \$500 and all rental items except Oxygen – no authorization required on Oxygen
- Experimental and Investigational services, devices, drugs
- Gamma Knife, Cyber knife
- Genetic testing / counseling
- Home health care infusions – (see attached list)
- Home health aide
- Hospice - inpatient
- Hyperbaric services
- Imaging - PET or PET/CT fusion scans; CT; CTA; CCTA; MRI; MRA
- Implantable pain & insulin pumps, spinal stimulators and trials, peripheral stimulators
- Injectable medications / infusions (see attached list)
- Lab tests for Specialty disease markers
- Neuropsych testing
- Non-cancerous breast reduction procedures (effective January 1, 2016)
- Nuclear cardiology in outpatient hospital setting CPT codes billed with A9500 or A9505
- Orthotics and prosthetics
- Pain management (all services beyond initial evaluation)
- Rehabilitation, full- or partial-day and inpatient; including cardiac and pulmonary rehab
- Rhinoplasty
- Septoplasty
- Sleep Studies
- Transplants
- Varicose vein surgical treatments including Sclerotherapy

Key Revisions: Effective 10/01/2012 adding authorization requirement for CT and MRI

PRE-CERTIFICATION LIST

Listed here are injectable medications / infusions that require pre-certification from Coventry Health Care prior to services being performed. Please call Coventry's Health Services department at 816-460-4670, or toll-free at 877-837-8914 with any questions.

- Actimmune
- Apokyn
- Aranesp
- Arcalyst
- Arixtra
- Avonex
- Betaseron
- Cimzia
- Copaxone
- Copegus
- Enbrel
- Epogen
- Extavia
- Forteo
- Fragmin
- Fuzeon
- Growth Hormone
- HCV
- Humira
- Ilaris
- Increlex
- Innohep
- Intron-A
- IVIG
- Kineret
- Leukine
- Lovenox
- Neulasta
- Neupogen
- Omnitrope
- Pegasys
- PegIntron
- Procrit
- Rebetol
- Rebif
- Sandostatin
- Serostim
- Simponi
- Somavert
- Stelara
- Teutropin
- Vivaglobin
- Zorbtive