Healthe Options Component Plan and Summary Plan Description
Effective January 01, 2016
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Health Reimbursement Account

Participants enrolled in the Healthe Options Component will receive an allocation (a “Health Allocation”) from Cerner to the Subscriber’s Health Reimbursement Account (“HRA”). The Subscriber will be charged a premium for their participation in the Plan. The premiums can be found in the United States Benefit Brochure, located on the Cerner intranet. If you do not have access to the Cerner intranet, please contact the Benefits Team to request a copy. Participants can use their HRA to cover 100% of the cost of Covered services, up to the accrued allocation in the Participant’s HRA. Covered services are set forth in this document.

Online Resources

Participants will have access to information and resources to help improve his/her health and better manage his/her health care. Cerner HealthPlan Services offers a web site, www.cernerhps.com, where a Participant can check his/her claim status and obtain information pertaining to his/her health services and expenses.

Before using Plan benefits, Participants need to know – and understand – how the Plan works. Participants should read this Plan thoroughly and refer to it as necessary. Contact Cerner HealthPlan Services Customer Service at 1-877-765-1033 or Cerner Benefits with questions about this Plan.

About This Plan Document and Summary Plan Description

The Healthe Options Component Plan & Summary Plan Description is part of the Cerner Corporation Wraparound Benefits Plan & Summary Plan Description, (the “Wraparound Benefits Plan & SPD”). This document, along with the Wraparound Benefits Plan & SPD, serves as both the Plan document and the Summary Plan Description (the “Plan”).

Cerner reserves the right to amend or terminate the Plan at any time. Participants will be notified of any changes that affect their benefits, as required by federal law.

Joining the Program

Associate Eligibility

All Associates working a standard 24 hours per week or more for Cerner are eligible. In addition, all Associates classified as “Senior Advisors” who meet the following requirements at the time of enrollment are eligible:

1. The Associate must be approved for a Special Employment Agreement (“SEA”);
2. The Associate must perform 60 hours per quarter of work activities, or if the Associate holds the title of Founder Emeritus, the Associate must perform 20 hours or more of work activities per quarter; and
3. The Associate must have a minimum of 3 years of continuous service with Cerner or a Predecessor Employer, and be 50 years of age or older.

Associates working less than a standard 24 hours per week, or with an Associate class of “Intern” are ineligible, unless such Associate is a Variable Hour Associate and works an average of 30 hours per week during the applicable measurement period. See the Variable Hour Associate section for more information. “Global Assignees” are also ineligible.
If an Associate’s coverage terminates by reason of layoff, termination of employment or leave of absence, and he/she resumes employment with Cerner, he/she is eligible for coverage on the date he/she resumes employment.

**Dependent Eligibility**

Associates may enroll his/her “Dependents” under the Plan. A “Dependent” eligible under the Plan is:

1. A Spouse, unless separated by a judicial decree of legal separation. For purposes of this Plan, a Spouse means a husband or wife as defined or recognized under state law for the purposes of marriage in the state where the marriage was celebrated and common law marriage as recognized in the state where the Associate resides.

2. A Child means either of the following:
   a. A child that meets the definition of a “qualifying child” under Code Section 152, as modified by Code Section 105(b). Notwithstanding the foregoing, Child includes the Associate's biological child, stepchild, adopted child, or foster child who has not yet attained age 26.
   
   b. A child for whom the Associate is the court appointed legal guardian.

   If the Child is permanently and totally disabled he or she may be Covered under the Plan regardless of his or her age. The Associate must provide substantiation from the individual's physician of the individual's permanent and total disability. Such substantiation must be provided within 31 days of the individual’s enrollment or disability, whichever is later.

3. A “Domestic Partner.” For benefits eligibility, Domestic Partners are persons who have a registered domestic partnership in any State or local municipality. Domestic Partners are subject to the same enrollment rules as other Dependents.

   Once Covered, Domestic Partners (and their enrolled Dependents) receive equivalent benefits as Spouses (and their enrolled Dependents), including continuation of coverage through COBRA and/or individual conversion.

4. The children of a Covered Domestic Partner.

   Children of a Covered Domestic Partner are also eligible to be Covered under the same Plan and terms as the Domestic Partner so long as the child has not yet attained age 26.

5. A child named as an alternate recipient under a state domestic relations order, or who is the subject of a court or administrative order seeking to enforce a law relating to medical child support, which order is determined by the Plan Administrator to be a “qualified medical child support order” (as defined in Section 609 of ERISA).

   If a Dependent also works for Cerner, he or she may be Covered as an Associate or a Dependent, but not both. If both parents are Associates of Cerner only one parent can cover the child(ren). A Dependent may not be Covered by more than one Associate.

   Proof of a Dependent’s eligibility may be requested at any time and must be provided within 31 days of such request ("Eligibility Request Period") or the Dependent's coverage may be terminated. If, based on the information provided, it is determined that a Dependent is ineligible for coverage under the Plan, the Dependent's coverage will terminate as of the date Cerner informs the Dependent that he or she is ineligible for coverage. If proof of a Dependent’s eligibility is not provided within the Eligibility Request Period, the Dependent’s coverage will terminate immediately following the last day of the Eligibility Request Period.

   Notwithstanding the previous paragraph, if it is determined that a Dependent is ineligible for coverage under the Plan and the Dependent's coverage was a result of fraud or an intentional misrepresentation of material
fact, such coverage will be terminated, following a 30-day notice period, as of the date of the Plan Administrator’s request or the date of ineligibility, whichever comes first.

**Enrolling in the Plan**

If an Associate wants to be Covered by the Plan, the Associate must enroll for this coverage by completing an enrollment election within 31 days of first becoming eligible and according to the process defined by Cerner.

If an Associate has enrolled for dependent coverage the Dependent may not be Covered under the Plan until the Associate is Covered under the Plan.

**Initial Enrollment Period**

If an Associate does not elect to participate in the Plan within the Initial Enrollment Period, such Associate shall be considered a Late Enrollee. The Initial Enrollment Period is the period of 31 days immediately following an Associate's initial eligibility.

**Late Enrollees**

If a newly hired Associate waits longer than the 31 days following his/her first day of employment to enroll in the Plan, the Associate and his/her Dependents are considered “Late Enrollees.” Late Enrollees shall be eligible to participate only during a Special Enrollment Period or Annual Enrollment Period thereafter. Coverage will not become effective until the first day of the Plan Year following the Annual Enrollment Period or as specified in the Special Enrollment Period.

**Annual Enrollment Period**

An Annual Enrollment Period will be held by the Plan. With the exception of Special Enrollment Periods, this Annual Enrollment Period is the only time when Late Enrollees may enroll in the Plan. In addition, if this Plan offers any optional coverages those optional coverages may be elected only during the Annual Enrollment Period.

**Special Enrollment Period for Loss of Other Credible Coverage**

In the event that an Associate or his/her Dependent(s) declines coverage under this Plan due to the existence of other health coverage and such other health coverage is subsequently terminated due to (a) loss of eligibility for such coverage (loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of the coverage for cause such as making a fraudulent claim or for misrepresentation), or (b) the termination of any company contributions for such coverage, then the Associate and his/her Dependent(s) may enroll in this Plan, provided a properly completed enrollment election is received by the Plan Administrator within 31 days of the loss of other coverage or termination of company contributions. In such a case, the Effective Date of coverage will be the date of the event or the date on which the new election was submitted, whichever is later.

**Special Enrollment Period for Newly Acquired Dependents**

If an Associate acquires a new Dependent, he or she should notify the Benefits Team immediately.

If an Associate acquires a new Dependent through birth, adoption or placement for adoption and submits an enrollment election to the Plan within 90 days of the birth, date of adoption or placement for adoption, coverage for the new Dependent will become effective on the date of the birth, date of adoption or placement for adoption. If the enrollment election is received more than 31 days after the birth, any increase in premium generally will be payable by the Associate on an after-tax basis for the remainder of the Plan Year. The tax treatment of premium payments is governed by the Cerner Corporation Flexible Spending Account Plan.
If an Associate acquires a new Dependent through marriage or a Domestic Partnership and submits an enrollment election to the Plan within 31 days of the event in question, coverage for the new Dependent will become effective on the date of the event or date on which the election was submitted, whichever is later.

An Associate and an Associate’s Spouse or Domestic Partner may also enroll during the Special Enrollment Period for newly acquired Dependents.

Special Enrollment Period Due to Medicaid and CHIPRA Coverage

In the event that an Associate or his/her Dependent(s) declines coverage under this Plan due to health coverage under Medicaid or a state child health plan under title XXI of the Social Security Act (“CHIPRA”) and (i) such individual loses coverage for Medicaid or CHIP due to loss of eligibility for such coverage, or (ii) such individual becomes eligible for assistance with the cost of participating in the Plan through the Medicaid plan or CHIP, then such Associate and/or his/her Dependent(s) may enroll in this Plan, provided that the Associate and/or the Dependent properly complete and submit an enrollment election to the Plan Administrator within 60 days of the loss of Medicaid or CHIP coverage or eligibility for the subsidy.

Changing Plan Coverage

Each year Associates must elect among the various benefits offered under the Plan. Outside of this Annual Enrollment and the Special Enrollment Periods outlined above, an Associate may only change his or her enrollment options (and those of the Associate’s Dependents) if the Associate experiences a Change in Status or a Qualifying Event.

To change Plan Coverage due to an eligible Change in Status or Qualifying Event, an Associate must notify the Plan Administrator and submit a new election within 31 days of the event provided that the Associate submits a new election within 31 days after the Change in Status or Qualifying Event, the effective date for such new election will be the date of the Qualifying Event or Change in Status, or the date on which the new election was submitted, whichever is later.

Change in Status

Any Associate may revoke a benefit election under this Plan and make a new benefit election for the remaining portion of the Plan Year if, under the facts and circumstances, a Change in Status occurs and the election change is consistent with the Change in Status.

The following events are Changes in Status:

1. a change in the Associate’s legal marital status, including marriage or beginning of a registered Domestic Partnership, death, divorce, or ending a registered Domestic Partnership, legal separation, and annulment;

2. changing the number of the Associate’s Dependent(s), including through birth, death, adoption, and placement for adoption;

3. a change in the employment status of the Associate or Dependent, including the termination or commencement of employment, a reduction or increase in hours of employment which affects an Associate’s eligibility to participate, including the switching from part-time to full-time employment status (or from full-time to part-time status), the commencement or return from an unpaid leave of absence, lockout or strike by the Associate or Dependent, or a change in the employment status of the Associate or Dependent which causes the individual to become (or cease to be) eligible under another employer's plan;

4. an event that causes the Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, or any similar circumstances; and
5. a change in the place of residence of the Associate or Dependent that affects eligibility for Coverage.

Changes in Plan coverage made as a result of a Change in Status must be consistent with the change. An Associate's revocation of a benefit election during the Plan Year and a new election for the remaining portion of the Plan Year (referred to below as an "election change") is consistent with a Change in Status only if:

1. the Change in Status results in the Associate or Dependent gaining or losing eligibility for coverage under the Plan; and

2. the benefit election change corresponds with that gain or loss of coverage.

For example, if as a result of a Change in Status, the individual gains eligibility for elective coverage under a plan of the Dependent's employer, the consistency rules are satisfied only if the affected individual elects the coverage under the Dependent's employer's plan.

Note: If the biological mother is a Covered Participant, that mother's newborn child is considered a Dependent under the Plan immediately after birth until he/she is discharged from the hospital or is 7 days old. If an Associate wants to continue coverage for the newborn child beyond that date, the Associate must enroll the newborn child.

**Qualifying Events**

Any Associate may revoke a benefit election under this Plan and make a new benefit election for the remaining portion of the Plan Year upon the occurrence of any of the following events:

1. Changes Based on Judgment, Decree, or Order. A judgment, decree, or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order as defined in Section 609 of ERISA) that requires accident or health coverage for an Associate's child. The Plan may:
   a. change the Associate's benefit election to provide coverage for the child if the order requires coverage under the Associate's Plan, provided that if the Associate is not enrolled in the Plan, the Plan will enroll both the Associate and the child; or
   b. permit the Associate to make a benefit election change to cancel coverage for the child if the order requires the former Spouse or Domestic Partner to provide coverage.

2. Changes Based on Entitlement to Medicare or Medicaid. If a Participant becomes enrolled in Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Associate may cancel or reduce coverage of such Participant.

3. Changes Based on FMLA Leave. An Associate taking leave under the FMLA may revoke Plan coverage, and may make such other benefit election for the remaining portion of the period of coverage as may be provided for under the FMLA.

4. Significant Cost Changes. If the cost that is charged to an Associate for this Plan significantly increases or decreases, the Associate may make a corresponding change. For example, if the cost significantly increases the Associate may switch to a Plan option with a lower cost or may drop coverage altogether.

5. Changes Based on Curtailment of Coverage. If coverage offered under this Plan is significantly curtailed or terminated during the Plan Year, an affected Associate may elect another option providing similar coverage. In this context, coverage under the Plan is significantly curtailed only if there is an overall reduction in coverage that affects all Associates.
6. Changes Based on Coverage Under Another Employer Plan. The Associate may make an election change that is on account of and corresponds to a change made under another employer plan, provided that the other plan permits participants to make a change for a period of coverage than is different than the period of coverage under this Plan. For example, if an Associate becomes enrolled in medical coverage under a plan sponsored by the employer of the Associate’s Spouse or Domestic Partner, then depending on the plan year of the other plan, the Associate may be able to drop coverage under this Plan.

7. Other Changes as Determined by the Plan Administrator. The Plan Administrator may determine by written policy any other permissible benefit election changes, provided that such changes are allowed by and are acceptable under rules and regulations adopted by the Treasury Department. Such determination shall be made on a nondiscriminatory basis in accordance with uniform principles consistently applied.

8. Transfer of Coverage. If a husband and wife, or Domestic Partners, are both validly covered as Associates under the Plan and one of them terminates coverage under the Plan as an Associate, the terminating Spouse, or Domestic Partner, and any Covered Dependents may immediately enroll under the remaining Associate’s coverage. Coverage shall be deemed a continuation of prior coverage and shall not operate to reduce or increase any coverage to which the person was entitled while enrolled as an Associate or Dependent of an Associate.

How the Plan Works

The Plan is an innovative approach to health benefits that puts Participants in charge of the money they spend for health care services and helps Associates get the most out of Cerner-sponsored health coverage. With this Plan, Associates have flexibility and control in choosing the health care services Associates and their Dependents receive – and in determining how the cost of these services is paid.

ID Cards

The Plan requires Participants to use an identification card to receive benefits. Participants should present the card each time he/she visits a health provider.

If a Participant visits a provider who offers Cerner discounts and such Participant presents his/her ID card, the claim – in most cases – will be submitted by the provider to Cigna for network pricing. If a Participant doesn’t present his/her ID card, he/she may need to pay for services him/herself and file a claim for reimbursement at a later date.

Note: While the ID card provides the information needed to identify the type of health care coverage a Participant has, this does not necessarily mean the Plan will pay benefits for this care. The terms and conditions of this Plan govern the amount of benefits payable. Be sure to check with Cerner HealthPlan Services to confirm eligibility and the extent of benefit coverage under the Plan.

Health Reimbursement Account

A Health Reimbursement Account (HRA) combined with underlying group health plan coverage provides traditional medical coverage and a tax free way to help Participants save for future medical expenses. The HRA provides greater flexibility and discretion over how Participants use their health care benefits.

Upon enrollment, the Plan makes an allocation for the Plan Year (in accordance with the Health Account Allocation table set forth below) to the Subscriber’s HRA. A Subscriber’s Deductible portion may be paid with funds from such Subscriber’s HRA.
The Cerner Health Plan will provide a $400.00 Health Reimbursement Account to each Subscriber, which may be used by such Subscriber and their Covered Dependents.

Plan Year enrollees will receive a pro-rated contribution to their HRA and will be credited for each full calendar month based on their coverage Effective Date.

If a Subscriber is (i) a Transitioned Associate or (ii) is hired by Cerner in conjunction with a merger or acquisition made by Cerner, then the Subscriber’s coverage Effective Date for purposes of the HRA will be the date of their most recent hire with his or her previous employer (but will not be earlier than January 1, 2016).

Example:

Health Plan coverage Effective Date is March 10, 2016

Cerner allocation to the HRA will be $300.00

$400.00/12 = $33.33 mo times 9 full months of enrollment in the Plan based on date coverage begins

<table>
<thead>
<tr>
<th>Enrollment Month</th>
<th>Health Allocation</th>
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<tr>
<td>January</td>
<td>$366.67</td>
</tr>
<tr>
<td>February</td>
<td>$333.34</td>
</tr>
<tr>
<td>March</td>
<td>$300.00</td>
</tr>
<tr>
<td>April</td>
<td>$266.67</td>
</tr>
<tr>
<td>May</td>
<td>$233.34</td>
</tr>
<tr>
<td>June</td>
<td>$200.00</td>
</tr>
<tr>
<td>July</td>
<td>$166.67</td>
</tr>
<tr>
<td>August</td>
<td>$133.34</td>
</tr>
<tr>
<td>September</td>
<td>$100.00</td>
</tr>
<tr>
<td>October</td>
<td>$66.67</td>
</tr>
<tr>
<td>November</td>
<td>$33.34</td>
</tr>
<tr>
<td>December</td>
<td>$0.00</td>
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If a Subscriber elects to cease participation in the Plan, all HRA dollars are forfeited. If a Subscriber changes their status to a Covered Dependent, the Subscriber will not receive any new HRA allocations but may continue to have access to the balance of their prior HRA, provided that the individual remains continually Covered by the Plan and they provide proper notification to Cerner HealthPlan Services of their change in status. The individual may use their HRA funds (until they are exhausted) to pay qualified medical expenses incurred by such individual and anyone who would be considered that individual’s Covered Dependent if the individual’s enrollment status were as Subscriber. **Affected individuals must notify Cerner HealthPlan Services Member Services at 1-877-765-1033 within 45 days of their change in status to ensure their HRA is not forfeited.**

**Qualified HRA Expenses**

The HRA may only be used for Qualified Medical Expenses for the Subscriber and their Covered Dependents. For a list of IRS Qualified Medical Expenses, please reference the IRS website.

- **Important:** Not all IRS Qualified Medical Expenses are Covered expenses under the Plan. Only Covered expenses are applied towards the Deductible and Cost Share. Expenses not Covered can
be deducted from the HRA, but are not eligible to be applied towards the Deductible or Annual Maximum.

If Subscribers don’t use the full amount of their HRA in a Plan Year, the remaining amount will be rolled over and used the next Plan Year.

**HRA Opt Out**

Benefits provided by an HRA constitutes minimum essential coverage and may preclude an individual from receiving tax credits or subsidies if enrolling in a public Healthcare Marketplace. Associates may choose to opt out of receiving the HRA allocation each year and, upon termination of employment, may permanently opt out of and waive future reimbursements from the HRA. To opt out of the HRA allocation, please contact the HR Service Center to complete the appropriate documentation. By opting out, you will be opting out of the following:

- Annual HRA funding
- HRA funding through the Healthe Living with Rewards program

**Cost of Coverage**

Subscribers and Cerner share the cost of the coverage for premiums under the Plan. A Subscriber’s cost for this coverage will be deducted from his/her pay each pay period on a before-tax basis unless otherwise prohibited. This means that the Subscriber’s cost for coverage is taken from his/her salary before income and Social Security taxes are calculated. This reduces the Subscriber’s taxable income and the amount of taxes he/she pays. Unless otherwise specifically set forth in this Plan, the Subscriber must pay a bi-weekly premium to the Plan as determined from time to time by Cerner in order to cover him/herself and his/her Dependent(s) under the Plan. Failure by the Subscriber to timely pay the applicable premiums may result in termination from the Plan.

For information on specific premium contribution rates refer to the Price Tags on the Cerner intranet. In addition to the premium contribution rates, the Plan requires Deductible and Cost Sharing responsibilities.

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<th>Deductible*</th>
<th>Cost Share**</th>
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<td>The amount you owe for Covered services before the Plan begins to pay. Participants are responsible for 100% of the Deductible. For example, if your deductible is $1,400, the Plan won’t pay anything until you’ve paid $1,400 for Covered services that are subject to the Deductible. The Deductible does not apply to all Covered services.</td>
<td>The percentage of Covered services paid separately by the Plan and the Participant after the Deductible has been met. For in-network providers, the Plan pays 85% and the Participant pays 15%. Once the Participant meets the Annual Maximum, the Cost Share generally does not apply. For more details, see “Schedule of Coverage.”</td>
<td>The maximum dollar amount a Participant is generally required to pay out of pocket for Covered services during the Plan Year. Until the Annual Maximum is met, the Plan and Participant share in the cost of Covered services. After the Annual Maximum is met, the Plan generally pays 100% of Covered services. For more details, see “Schedule of Coverage.”</td>
</tr>
</tbody>
</table>
services, such as preventive care services, which are covered by the Plan at 100%.

| details, see “Schedule of Coverage.” |

*Deductible and Cost Share responsibilities may be paid using available HRA dollars and/or dollars from an eligible health care flexible spending account.

** The Cost Share amounts may vary depending upon the network status of a provider and/or the services provided.

Amounts a Participant pays toward the cost of certain medical services will not count toward the Deductible, Cost Share and Annual Maximum responsibilities. These include any cost paid:

- for any service that is not a Covered service under the Plan, and
- expenses that are in excess of Allowable Charges.
## Health Plan Summary

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Deductible</th>
<th>Cost Share % &amp; max</th>
<th>Annual Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Only</td>
<td>$1,400</td>
<td>15% up to $1000</td>
<td>$2,400</td>
</tr>
<tr>
<td>Associate + Child</td>
<td>$2,000</td>
<td>15% up to $1,400</td>
<td>$3,400</td>
</tr>
<tr>
<td>Associate + Spouse or Domestic Partner</td>
<td>$2,200</td>
<td>15% up to $1,600</td>
<td>$3,800</td>
</tr>
<tr>
<td>Associate + 2 Children</td>
<td>$2,200</td>
<td>15% up to $1,600</td>
<td>$3,800</td>
</tr>
<tr>
<td>Associate + 3 Children</td>
<td>$2,300</td>
<td>15% up to $1,600</td>
<td>$3,900</td>
</tr>
<tr>
<td>Associate + 4 or more Children</td>
<td>$2,400</td>
<td>15% up to $1,600</td>
<td>$4,000</td>
</tr>
<tr>
<td>Associate + Spouse or Domestic Partner + Child</td>
<td>$2,600</td>
<td>15% up to $2,000</td>
<td>$4,600</td>
</tr>
<tr>
<td>Associate + Spouse or Domestic Partner + 2 Children</td>
<td>$2,800</td>
<td>15% up to $2,000</td>
<td>$4,800</td>
</tr>
<tr>
<td>Associate + Spouse or Domestic Partner + 3 Children</td>
<td>$2,900</td>
<td>15% up to $2,000</td>
<td>$4,900</td>
</tr>
<tr>
<td>Associate + Spouse or Domestic Partner + 4 or more Children</td>
<td>$3,000</td>
<td>15% up to $2,000</td>
<td>$5,000</td>
</tr>
</tbody>
</table>
**Deductible Credit**

The Plan will allow credit for deductibles met under (i) another Cerner-sponsored health care plan, (ii) a health care plan sponsored by a Transitioned Associate’s prior employer, and (iii) if a member is hired by Cerner as part of a Cerner merger or acquisition, a health care plan sponsored by the member’s prior employer, provided in each event, that a member of such plan enrolls in this Plan during their initial enrollment period under this Plan, and subject to the following conditions and limitations:

- The Participant will only receive credit for deductibles paid under the applicable prior plan for health care services that are rendered within this Plan’s current Plan Year.

- The deductible credit may not exceed the sum of the Participant’s Deductible under this Plan.

To receive deductible credit from another Cerner sponsored health care plan, the Participant must contact Cerner HealthPlan Services Customer Service at 1-877-765-1033 and provide substantiation of the deductible paid under their prior Cerner-sponsored health care plan. The Cerner Corporation Benefits Team will inform Subscribers who join Cerner as a result of a Cerner merger or acquisition how to receive this deductible credit.

The Plan will also provide credit for deductibles paid for health care services rendered within this Plan’s current Plan Year, applicable to Subscribers who become Covered Dependents under the Plan due to a mid-year change in status election, without a break in coverage. Affected individuals must contact Cerner HealthPlan Services Member Service at 1-877-765-1033 within 45 days of their change in status to receive this credit.
## Schedule of Coverage

<table>
<thead>
<tr>
<th>IN NETWORK</th>
<th>Before the Deductible is met...</th>
<th>After the Deductible is met and before the Annual Maximum is met...</th>
<th>After the Annual Maximum is met...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Emergency</strong></td>
<td>Participant pays 100% for all Covered services and supplies, except as specifically indicated in this Plan. (For example, Plan pays 100% of preventive care.)</td>
<td>Plan pays 85%. --- Participant pays 15%.</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td><strong>Emergency</strong></td>
<td>Participant pays 100%.</td>
<td>Plan pays 85%. --- Participant pays 15%.</td>
<td>Plan pays 100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUT OF NETWORK</th>
<th>Before the Deductible is met...</th>
<th>After the Deductible is met and before the Annual Maximum is met...</th>
<th>After the Annual Maximum is met...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Emergency</strong></td>
<td>Participant pays 100%.</td>
<td>Plan pays 65% of Allowable Charges. --- Participant pays remainder.</td>
<td>Plan pays 100% of Allowable Charges. --- Participant pays remainder.</td>
</tr>
<tr>
<td><strong>Emergency</strong></td>
<td>Participant pays 100%.</td>
<td>Plan pays 85% of Allowable Charges. --- Participant pays remainder.</td>
<td>Plan pays 100%</td>
</tr>
</tbody>
</table>

The terms “Emergency,” “Preventive Care,” and “Allowable Charges” are all defined elsewhere in this Plan. The amounts paid by the Participant that are counted toward the Deductible and the Annual Maximum are explained elsewhere in this SPD.

## Case Management

Participants who have a serious or extended illness or Injury may be appointed a case manager to assist the Participant in identifying and coordinating appropriate and cost-effective medical care alternatives. The case manager may also coordinate communication among the Participant and his/her health care providers involved in his/her care.

Plan benefits may be modified by the Plan Administrator to permit a method of treatment not expressly provided for, but not prohibited by law, rules or public policy, if the Plan Administrator determines that such modification is Medically Necessary and is more cost-effective than continuing a benefit to which the Participant may otherwise be entitled. The modified benefits will be coordinated with the Participant and his/her treating physician. The Plan Administrator also reserves the right to limit payment for Covered services to those amounts which would have been charged had the Covered services been provided in the safest and most cost-effective setting available.
**Health Plan discounts and Conditions Program**

The Plan provides special features that promote healthy living, including the Wellness Incentive Program and certain condition management programs. Information on the Wellness Incentive Program can be found in Appendix A, Healthie Living with Rewards Program. The Plan may also offer certain condition management programs, which are designed to educate and assist Participants and collaborate with providers for certain identified health conditions to achieve favorable health outcomes. If a Participant is eligible for a condition management program, the Plan or its providers may contact the Participant directly. Alternatively, if the Plan offers a condition management program that you are interested in, please contact Cerner HealthPlan Services to obtain more information.

**Providers**

The Plan offers network benefits to Participants through A Participant’s primary network is listed on the back of their ID Card.

In addition:

- if a Subscriber is an Associate of RevWorks, LLC, the Subscriber and his/her Dependents will use the RevWorks Preferred Network as their primary network. If medical care is needed outside of the RevWorks Preferred Network, Participants will use the network listed on the back of their card.
- if a Participant needs mental health and substance abuse services, the Participant will use the Cigna Behavioral Health network.

Participants can obtain electronic network provider directories, free of charge, by accessing the member site at www.cernerhps.com or by contacting the Cerner HealthPlan Services Customer Service Department at 1-877-765-1033. It is the Participant’s responsibility to determine whether a provider is a network provider each time he/she uses a provider. Under the Plan, Participants have the flexibility to see any licensed health care provider they choose. Cerner HealthPlan Services can help Participants locate a network provider near them. The level of health coverage under the Plan depends on whether a Participant uses providers who offer network discounts or providers who do not offer network discounts.

**Providers Who Offer Network Discounts**

If a Participant visits a provider who offers a network discount, he/she will receive the highest level of benefits offered under the Plan. These providers have agreed to charge a “discounted fee” for their services. Participants will never pay for charges in excess of the discounted price, and in most cases, the provider will file a claim for the Participant after his/her visit.

Cerner disclaims any warranty about the quality of care that may be rendered by any provider. Participants, together with their Doctor, are ultimately responsible for determining the appropriate course of medical treatment in any given case, regardless of whether or how much the Plan pays for the cost of such care.

**Inpatient Admission**

All elective inpatient admissions and transplant services are subject to pre-certification requirements. Providers participating with Cigna PPO are required to obtain pre-certification and to comply with Cigna’s pre-certification protocols. Participants who choose to obtain Inpatient services out-of-network, are responsible for completing the pre-certification process.

**Note:** Under federal law, benefits for any hospital stay in connection with childbirth for the mother or the newborn cannot be restricted to less than:
48 hours following a normal vaginal delivery
96 hours following a cesarean section

The Doctor, after consulting with the mother, may discharge the mother or newborn before the 48- or 96-hour timeframe noted above.

**Covered Services**

Services for which the Plan may pay benefits include the following hospital and medical services and supplies for treatment of an Injury or disease.

Most Covered services received from providers who offer a network discount will be Covered at 85% of discounted fees. Most Covered services received from out-of-network providers will be Covered at 65% of Allowable Charges.

**Allergy Care – Injections and Tests**

Allergy care is covered when administered by a Doctor, allergist, or specialist. Serum is covered only when received and administered within the provider’s office. If received from a pharmacy, the serum may be covered under the pharmaceutical benefit. The following services are Covered:

- **Allergy Injections- Immunotherapy**
  
  Also called allergy desensitization or allergy shots; immunotherapy is given to increase a person’s tolerance to the substances that provoke allergy symptoms (allergens). Allergy shots reduce the sensitivity to certain substances but do not cure allergies.

- **Allergy Tests**
  
  • An allergy **Skin Test**, also called a scratch test, is used to identify the substances that are causing allergy symptoms. It is the application of the allergen extract to the skin, and then scratching or pricking the skin to allow exposure, and evaluating the skin’s reaction. If no reaction has occurred after 30 minutes, the substance is removed and the test is considered negative. If there is redness or swelling at the scratch sites, the test is considered positive.
  
  • **RAST** (radioallergosorbent test) is a blood test used to identify the substances that are causing allergy symptoms and to estimate a relative sensitivity.

**Alternate Methods of Medical Care or Treatment**

Charges for alternate methods of medical care or treatment not otherwise listed as Covered charges (or a provider of medical treatment who is not listed as a Covered Provider), if, in the opinion of Cerner, such alternate methods or providers are Medically Necessary and less expensive than the other courses of medical care or treatment normally covered under the Plan. This does not, however, cover expenses that are considered Experimental as set forth in this Plan.

**Ambulance**

Professional ground transportation ambulance services are Covered at 85% regardless of network status in the following circumstances:

- When used to transport the Participant from the place of accidental Injury or serious medical incident to the nearest facility where treatment can be given.

- To transport the Participant from one hospital to another nearby hospital when the first hospital does not have the required services and/or facilities to treat the Participant.

- To transport the Participant from hospital to home, skilled nursing facility or nursing home when the patient cannot be safely or adequately transported in another way without endangering the Participant’s health, whether or not such other transportation is actually available.
• To transport a Participant from home to hospital for Medically Necessary Inpatient or Outpatient Treatment when an ambulance is required to safely and adequately transport the Participant.

• To transport a Participant upon medical stabilization from a non-discounted facility to a discounted facility when they were admitted due to a medical emergency to a non-discounted facility.

Coverage is provided for air ambulance transport for medical emergencies in the following circumstances:

• The Participant requires transport to a hospital or from one hospital to another because the first hospital does not have the required services and/or facilities to treat the Participant; and ground transportation is not medically appropriate because of the distance involved,

• Or because the Participant has an unstable condition requiring medical supervision and rapid transport.

Notification is required except in a life threatening circumstance.

Anesthesia
The administration of anesthesia, other than local infiltration anesthesia, in connection with a Covered surgical procedure which is performed at an in-network facility, is Covered at 85% regardless of network status, provided the anesthesia is administered and charged for by a Doctor other than the operating surgeon or his assistant.

Blood Transfusions
Coverage is provided for blood transfusions to maintain or replace blood volume, to provide deficient blood elements and improve coagulation, to maintain or improve transport of oxygen, and in exchange for blood that has been removed in the treatment of Rh incompatibility in the newborn, liver failure in which toxins accumulate in the blood, or in some other types of toxemia.

Coverage is included for the following:

• Autologous
• Direct Donation
• Regular Administration
• Whole Blood

BRCA Genetic Testing
Genetic testing for the BRCA 1 and BRCA 2 gene mutation testing will be Covered for high-risk adults as defined by the Patient Protection and Affordable Care Act (PPACA).

Breast Reconstruction Coverage
Coverage is provided for breast reconstruction following mastectomy or lumpectomy when the breast reconstruction is performed in a manner as determined by the Participant in consultation with the attending Doctor. Benefits include:

• Reconstruction of the breast on which the mastectomy or lumpectomy was performed;
• Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
• Prostheses and treatment of physical complications of all stages of mastectomy or lumpectomy.

Cardiac Rehabilitation Therapy
Coverage for cardiac rehabilitation therapy is provided in two phases. Phase I begins during/after the acute event (i.e. by-pass surgery, myocardial infarction, angioplasty). It includes nursing services, physical
therapy and teaching the Participant how to deal with his/her condition. Phase II is a hospital based outpatient program after Inpatient hospital discharge. It is Doctor directed with active treatment and EKG monitoring at a frequency of three (3) times per week for approximately twelve (12) weeks.

**Chiropractic**

Chiropractic services are defined as those services for the detection and correction by manual or mechanical means of nerve interference resulting from or related to misalignment or partial dislocation of or in the vertebral column. Coverage includes initial consultation and treatment. Benefits for chiropractic treatment are limited to a maximum of 52 visits per Plan Year.

**Dental Services and Oral Surgery**

Charges for care rendered by a Doctor or dentist, which are required as a result of an accidental Injury to the jaw, sound natural teeth, mouth or face, provided care commences within 90 days of the accident are Covered. Injury as a result of chewing or biting will not be considered an accidental Injury.

Charges for surgical benefits for cutting procedures for the treatment of disease, injuries, fractures and dislocations of the jaw when the service is performed by a Doctor or dentist are also considered Covered services.

**Note:** Normal extraction and care of teeth and structures directly supporting the teeth are not Covered.

**Diagnostic Labs and X-rays**

Coverage is provided when services are performed to diagnose specific symptoms or rule out medical conditions. Services include:

- Diagnostic X-ray, consisting of radiology, ultrasound, nuclear medicine and magnetic resonance imaging.
- Diagnostic laboratory and pathology tests.
- Diagnostic medical procedures consisting of EKG, EEG, and other electronic diagnostic medical procedures.
- Pre-admission pre-surgical tests which are made prior to a covered person’s Inpatient or outpatient surgery.

For pre-admission and/or post-release testing to be Covered, the Doctor must specify required tests and approve the facility for testing. In most cases, the tests can be performed in the outpatient department of a hospital, at an independent medical testing laboratory or in the Doctor’s office.

Pre-admission tests will be Covered even if hospitalization is delayed, postponed or cancelled.

**Dialysis Treatment**

Coverage is provided for the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body, to include hemodialysis or peritoneal dialysis.

**Durable Medical Equipment**

Coverage is provided for rental or, at the discretion of the Plan, purchase of Durable Medical Equipment (DME), which is prescribed by a Doctor and required for therapeutic use. Coverage for DME rentals will not exceed the cost to purchase such item.

If purchased, charges for repair or Medically Necessary replacement of DME will be considered a Covered expense. DME includes, but is not limited to crutches, commodes, hospital beds, nebulizers, monitoring equipment and wheelchairs. Coverage for DME rental shall not include exercise equipment, equipment
that is not solely for the use of the Participant, comfort items, routine maintenance, or DME for the convenience of the Participant.

**Breast Pump Reimbursement**
The Plan covers reimbursement for the purchase of a breast pump up to $270.00 for the nursing mother Participant in the event of a live birth or infant adoption. Documentation of the birth or adoption, along with the receipt verifying purchase, will be required. Claims must be filed within twelve months of the date of the live birth or the date of the adoption of an infant. The Participant will need to submit for reimbursement with the Plan Administrator, Cerner HealthPlan Services. Claim forms are available in the Forms library at Cernerhps.com. Participants receiving reimbursement for breast pumps purchased for amounts above the $270.00 limit may submit for the difference in the amount paid for the breast pump and the amount reimbursed, for reimbursement from available flexible spending account funds. One breast pump may be reimbursed per maternity event.

**Breast Pump Rental**
The Plan will cover breast pump rental at 100%. The rental of a breast pump must come from a Cerner approved rental provider.

All claims for breast pump rental will be reviewed for Medical Necessity, for example the Medical Necessity of a hospital grade breast pump. A hospital grade breast pump rental will be Covered for a maternity event resulting in multiple live births. One breast pump may be rented per maternity event.

**Breastfeeding Supplies**
The Plan will cover breastfeeding supplies for Covered breast pumps. Examples of approved supplies include:

- Tubing for breast pump, replacement
- Adapter for breast pump, replacement
- Cap for breast pump bottle, replacement
- Breast shield and splash protector for use with breast pump, replacement
- Polycarbonate bottle for use with breast pump, replacement
- Locking ring for breast pump, replacement

Examples of ineligible supplies are bottles, ice packs, and cleaning supplies.

**Emergency Room Care**
Emergency medical care meeting the following definition is also Covered:

Facility and professional provider services and supplies for the initial treatment of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

- Permanently placing a Participant’s health in jeopardy,
- Causing other serious medical consequences, or
- Causing serious impairment to bodily functions, or causing serious and permanent dysfunction of any bodily organ or part.

If the emergency room visit results in a hospital admission, Participants should notify Cerner HealthPlan Services within 48 hours of the admission.

Emergency room care as described above will be reimbursed at 85% for both in-network and out-of-network providers.
Emergency Room Care for Non-Emergencies
Emergency room care for non-emergencies will be reimbursed at 65% for both in-network and out-of-network providers. Care for non-emergencies is defined as care received in an emergency room for a service or condition that does not meet the prudent layperson's assessment of emergency (see description above in Emergency Room Care section).

Family Planning
The Plan will provide 100% coverage for the following forms of family planning for in-network providers:

- Hormonal
  - Generic oral contraceptives
  - Patches (100% coverage for brand products if no generic alternative exists)
  - Vaginal Rings (100% coverage for brand products if no generic alternative exists)
  - Injectables—(100% coverage for brand products if no generic alternative exists)
- Barrier Methods
  - Diaphragm for contraceptive use
  - Contraceptive IUD including implants and supplies
  - Levonorgestrel—releasing intrauterine contraceptive system (Mirena)
  - Cervical cap for contraceptive use
  - Diaphragm or cervical cap fitting with instructions
- Implants
  - Etonogestrel (contraceptive) implant system, including implants/supplies—Implanon
- Emergency Contraceptives
  - Lovonorgestrel (Plan B)
  - Ulipristal acetate (Ella)
- Sterilization Coverage (V25.2 Sterilization Only)
  - Tubal Procedure—minilaparotomy and laparoscopy
  - Hysteroscopic Procedure—Essure System
  - Hysteroscopy with bilateral fallopian tube cannulation

The Plan will also provide 100% coverage for contraception education and counseling.

Coverage for family planning is also provided for, but subject to the deductible and cost share:

- D & C/Abortion—therapeutic or voluntary
- Vasectomy

Note: Reversal of sterilization is not a Covered service.

Foreign Claims
Claims for services rendered while a Participant is out of the country, meaning the United States, are Covered at 85%. All monetary conversions and rate of exchange are calculated based on the date of service. If the Participant chooses to leave the United States to seek care, claims will be Covered at 65% of Allowable Charges.
Habilitative Services

Applied behavior analysis sensory and auditory integration therapies and facilitated communication therapy are collectively referred to as ABA Therapy. ABA Therapy is a structured program of intensive behavioral treatment.

Coverage for ABA Therapy is not available until a Qualifying Diagnosis (defined below) has been made by a physician that is board certified or board-eligible in behavioral developmental pediatrics, neurodevelopment pediatrics, pediatric neurology or child psychiatry or by a PhD clinical psychologist.

Qualifying diagnoses are:

- Autistic Disorder (AD),
- Childhood Disintegrative Disorder (CDD),
- Asperser’s Syndrome (AS), and
- Pervasive Developmental Disorder Not Otherwise Specified (PDDNOS)

A written treatment plan is required before services are rendered.

Hearing Aids

Examinations or treatment for the prescription or fitting of hearing aids are Covered at 85%. Hearing aids will be Covered one time every 3 years up to a maximum of $2,500.

Home Health Care

A Home Health Care facility is a hospital or a nonprofit or public agency which:

- Primarily provides skilled nursing services and other therapeutic services under the supervision of a Doctor or a Nurse;
- Is run according to rules established by a group of medical professionals;
- Maintains clinical records on all patients;
- Does not primarily provide Custodial Care or care and treatment of the mentally ill; and
- Is licensed and run according to the state and federal laws.

Home Health Care expenses are limited to 120 days per Participant per Plan year, are Covered if the services are provided by a licensed home health care agency, and:

- The charge is made by a home health care agency;
- The care is given according to a home health care treatment plan;
- The care is given to a person in his or her home; and
- The home health expenses are charges for:
  - Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available,
  - Part-time or intermittent home health aide services for patient care, and
  - Physical, occupational and speech therapy.

The following shall be Covered to the extent they would have been covered under the Plan if the Participant had been Confined in a hospital or convalescent facility:
• Medical supplies,
• Drugs and medicines provided by a Doctor, and
• Lab services provided by a home health care agency.

The following expenses are not Covered:

• Services or supplies that are not part of the home health care treatment plan,
• Services of a person who is a member of the Participant’s Immediate Family or a person residing in the Participant’s home,
• Services of a social worker,
• Transportation, and/or
• Services provided while the Participant is not under the continuing care of a Doctor.

**Home Ventilator Program**

The Plan will Cover up to $100,000 per Participant, per Plan year, for Infant Participants who qualify for a home ventilator program. A home ventilator program is a program offered by certain providers to Infants diagnosed with chronic respiratory failure, who need prolonged ventilator or trachea care assistance to have the opportunity to live at home rather than in an intensive care hospital environment. Coverage is provided until the Infant is weaned from the ventilator and decannulated or is in a developmental state that minimizes the risk for unexpected decannulation, or so long as the services are otherwise determined to be Medically Necessary.

Qualified Participants must be Infants who were diagnosed at birth with chronic respiratory failure. Covered services include:

• Primary home ventilator team usually consisting of neonatologists, an otolaryngologist, a registered nurse coordinator and a social worker; and
• Training period and multiple practice sessions with the equipment, plus coordination with the home nursing companies, the durable medical equipment companies and the primary care physicians to ensure continuity of care.

**Chronic respiratory failure** is a long-term lack of oxygen that may result from the following types of diagnosis: premature birth, hyaline membrane disease, muscular dystrophy, neurologic disorders, or congenital heart disease. These are examples of some types of diagnosis that may result in chronic respiratory failure; there may be other qualified diagnoses that your medical team identifies that also lead to chronic respiratory failure.

**Infant** under the Home Ventilator Program is defined as a child from birth to age 5.

In cases where the home ventilator program benefits are exhausted within a Plan year, the Participant will continue to be eligible for other Covered services under the Plan subject to any other benefit limitations or exclusions. Any required durable medical equipment to support the home ventilator program will be Covered as set forth under the subsection entitled Durable Medical Equipment.

**Hospice Care**

Hospice is a health care program providing a coordinated set of services rendered at home, in an outpatient setting or in an institutional setting, for those suffering from a condition that has a terminal prognosis.
To be Covered, the hospice program must be licensed and the attending Doctor must certify that the terminally ill Participant has a life expectancy of six months or less. Charges incurred during periods of remission are not eligible under the provision of the Plan.

Hospice care for Participants is Covered for up to six months. A health care manager is available to coordinate coverage beyond six months.

Services and supplies typically provided and billed by a hospice are:

- Inpatient care
- Nutrition counseling and special meals
- Part-time nursing
- Homemaker services
- Bereavement counseling for the Immediate Family during the six month period following the date of death, limited to a combined maximum of $500 per death
- Respite care—limited to 5 days per hospice stay
- Physical and chemical therapy

**Hospital and Facility Services**

A hospital is defined as an institution which is accredited by the Joint Commission on Accreditation of Healthcare Organizations or any institution which is legally operated as a hospital, and:

- provides diagnosis, treatment and medical care of Injured and sick individuals on an Inpatient basis;
- has a staff of one or more Doctors available at all times;
- provides 24-hour nursing service; and
- is not, other than incidentally, a convalescent facility or a place for aged individuals.

**Immunizations or Oral Prescriptions for Travel**

Immunizations or oral prescriptions for travel are covered, such as:

- Yellow fever
- Typhoid

**Infertility Treatment**

Coverage is provided for the initial evaluation treatment and correction of the underlying condition only.

Procedures that may produce a pregnancy, but do not correct the underlying cause of the infertility are not Covered.

**Not Covered Treatments:**

- Artificial Insemination
- Drug Therapy
- In-vitro fertilization
- Gamete (GIFT) and zygote (ZIFT) intrafallopian transfer procedures
- Drugs related to the inducement of pregnancy
Inpatient Medical Facility

**Inpatient Room and Board**
Coverage provided for room and board is limited to the Semi-Private Room Rate. Private room, intensive care, coronary care and other specialized care units of a facility are covered when such special care or isolation is consistent with professional standards for the care of the Participant’s condition.

When room and board for other than semi-private care is at the convenience of the Participant, payment will be made only at the Semi-Private Room Rate.

**Inpatient Ancillary Charges**
Ancillary services and supplies are covered during an inpatient stay, including, but not limited to use of operating, delivery, and treatment rooms; prescribed drugs; whole blood, administration of blood, blood processing, and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced); anesthesia, anesthesia supplies and the administration of anesthesia by an employee of the facility; medical and surgical dressings, supplies, casts and splints; diagnostic services; and therapy services; but not services of a Doctor, or drugs or supplies not consumed or used in the facility.

**Inpatient Rehabilitation Facility**
Coverage is provided for inpatient rehabilitation facilities, subject to certain limits as set forth in this Plan. Most people who are admitted to an inpatient rehabilitation facility are recovering from injuries or illnesses that severely impair their physical functioning or understanding. These include strokes, spinal cord injuries, traumatic brain injuries, chronic pulmonary problems, neurological disorders and other debilitating conditions.

Administered by treatment teams, individual patient programs can include these services:

- Behavioral medicine
- Case management
- Dialysis
- Nutrition services
- Neuropsychology
- Occupational therapy (OT)
- On-site orthotic and prosthetic services
- Physical therapy (PT)
- Psychology
- Recreation therapy
- Rehabilitation engineering and technology
- Rehabilitation nursing
- Social work
- Speech and language therapy
- Vocational and community re-entry services

**Maternity Care**
Benefits are payable for pregnancy-related expenses of Participants on the same basis as a Covered illness. The expenses must be incurred while the Participant is Covered under the Plan.
Also Covered are services rendered in a Birthing Facility, provided that the Doctor in charge is acting within the scope of his license and the Birthing Facility meets all legal requirements.

If the biological mother is a Covered Participant, that mother’s newborn child is considered a Dependent under the Plan immediately after birth until he/she is discharged from the hospital or is 7 days old. If an Associate wants to continue coverage for the newborn child beyond that date, the Associate must enroll the newborn child.

**Cerner Certified Maternity Partner Hospital Benefits**

Participants who choose to deliver at a Cerner Certified Maternity Partner will be eligible for additional services without cost to the Participant such as:

- Lactation visits
- Optional home visit
- Meal vouchers during the hospital stay
- A T-Dap immunization for a support person

Participants who choose to deliver at a Cerner Certified Maternity Partner will be invited by Cerner HealthPlan Services to complete a survey following delivery. Upon completion of this survey, the Subscriber will be eligible for a $500 incentive, taxable as normal income.

**Medical Supplies**

Medical supplies that are prescribed by a licensed provider for a medical condition or diagnosis are covered, except for those that are available over-the-counter. Over-the-counter supplies are excluded from the Plan (except that certain over-the-counter supplies may be purchased with the HRA provided that they are IRS Qualified Medical Expenses).

Examples of medical supplies are diabetic supplies (lancets, glucometers, syringes, if not covered under the pharmacy benefit), injectables, ostomy supplies (including medical equipment and supplies directly related to ostomy care when surgery creates an opening for drainage from the kidney, the small intestines or the colon), and Medically Necessary eyeglasses after cataract surgery. (Coverage will be provided for one pair of glasses or contact lenses following cataract surgery up to a $300 maximum. If the Participant elects upgraded frames and/or lenses, the Plan will only reimburse for the standard frame and lens amount.)

**Mental Health/Chemical Dependency**

The Plan provides coverage for both mental health and chemical dependency care services. For a list of in-network providers, please visit [http://www.cigna.com/hcpdirectory](http://www.cigna.com/hcpdirectory) and select the Cigna Behavioral Health Directory.

Mental Health is defined as psychosis, neurosis or emotional disorder or any disease or condition that is classified as a mental disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Chemical dependency is defined as consumption of alcohol or other drugs in amounts that place an individual's social, economic, psychological and physical welfare in potential hazard or that cause an individual, while habitually under the influence of alcohol or drugs, to endanger public health, morals, safety or welfare.

Services Covered for a Participant’s mental health and chemical dependency include:
• Inpatient Mental Health and Chemical Dependency Treatment
• Outpatient Mental Health and Chemical Dependency Treatment

**Inpatient and Residential Treatment Center Mental Health and Chemical Dependency Services**

An acute Inpatient hospitalization is described as treatment that includes 24-hour nursing and daily, active treatment under the direction of a psychiatrist, or for children and adolescents, a board certified/eligible child and adolescent psychiatrist.

A Residential Treatment Center is medically supervised, psychiatric residential treatment—a level of care that includes individualized and intensive treatment on a 24-hour basis in a residential setting.

Charges for a facility and professional provider related to or because of psychiatric illness are Covered as follows:

• Inpatient facility charges;
• Individual Psychotherapy;
• Group Psychotherapy;
• Psychological Testing;
• Counseling with Immediate Family members to assist in the Participant’s diagnosis and treatment; and
• Electro-Convulsive Therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same professional provider.

**Outpatient Mental Health and Chemical Dependency Treatment**

Outpatient mental health treatment and chemical dependency treatment is described as the diagnosis or treatment of a mental disease, disorder, or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as revised, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin. Care must be provided by a Doctor or licensed mental health/chemical dependency provider. Covered services include but are not limited to:

• Assessment,
• Diagnosis,
• Individual, group, family or conjoint psychotherapy,
• Medication management
• Psychological testing and assessment,
• Electroconvulsive treatment (ECT),
• Crisis intervention, and
• Rehabilitation (drug and alcohol related).

**Nutritional Counseling**

Coverage is provided for health services rendered by a registered dietician, or other licensed provider, for Participants with medical conditions that require a special diet. Some examples of such medical conditions include diabetes mellitus, coronary heart disease, congestive heart failure, severe obstructive airway disease, gout, renal failure, phenylketonuria and hyperlipidemia. Coverage for nutritional counseling that
exceeds twelve (12) visits per Participant per Plan year will require approval. Please contact Cerner HealthPlan Services at 877-765-1033 for more information.

**Orthotic Devices**

Coverage is provided for orthotic devices (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including custom shoes and custom molded inserts, if prescribed by a Doctor. Coverage will be limited to one pair of custom shoes or custom molded inserts per year, up to an annual maximum of $400, unless related to a diagnosis of diabetes, in which case there will not be a cap.

**Podiatry**

Coverage is provided for certain surgical podiatry services, including incision and drainage of infected tissue of the foot, removal of lesions of the foot, removal or debridement of infected toenails, and treatment of fractures and dislocations of bones of the foot. Podiatry services not covered are those procedures considered to be a part of a routine foot care or of a cosmetic nature.

**Prescription Drug Benefits**

Prescription drug coverage is provided for Medically Necessary outpatient prescription drugs and supplies prescribed by a qualified Doctor or licensed nurse practitioner. Participants must be Covered at the time the prescription or refill is filled. For a list of participating pharmacies, contact Cerner HealthPlan Services Customer Service at 1-877-765-1033 or visit the Cerner HealthPlan Services website (www.cernerhps.com).

*Pharmacy Benefits*

The Plan contracts with a number of retail pharmacies and a mail order pharmacy that offers a discount on prescription drugs. If prescriptions are filled at a pharmacy, pharmacies are able to provide up to a 30-day* supply. Mail order prescriptions are eligible to be filled up to a 90-day supply.

* Pharmacies that participate in the MedTrak P90 program and Cerner’s Health Clinic pharmacy may be able to provide up to a 90-day supply.

Selected generic depression and anxiety prescriptions will be Covered at 100%. These prescriptions (i) will automatically process as 100% Plan Covered when filled at any in-network pharmacy, and (ii) are not subject to Deductible or Cost Share. For a list of eligible prescriptions please go to www.cernerhps.com.

Selected contraceptive prescriptions will be Covered at 100%. These prescriptions (i) will automatically process as 100% Plan covered when filled at any in-network pharmacy and (ii) are not subject to deductible or cost share. For a list of eligible prescriptions, please go to www.cernerhps.com.

**Asthma and COPD Management**

For Participants with an active Asthma and/or COPD diagnosis, Inhaled Corticosteroids and Inhaled Anticholinergics will be Covered at 100% after the first fill, if:

- The Participant enrolls in the Asthma / COPD Management program with the Pharmacy Advocacy team; and
- Meets the continuous enrollment requirements under the Asthma/COPD Management program, including regular consultations with the Pharmacy Advocacy team.

The Participant is responsible for any applicable deductible and cost share amounts applied to Inhaled Corticosteroids and Inhaled Anticholinergics prior to enrollment in the program. An enrollment
opportunity for the program is triggered after the initial fill of the applicable medication. To enroll in the program, the Participant will be contacted by the Pharmacy Advocacy team, who will verify that an asthma and/or COPD diagnosis exists. If deemed eligible, the Participant will enroll in the program with the Pharmacy Advocacy team. Participants cannot pre-enroll to receive the benefit, avoiding out-of-pocket costs for the first fill.

For eligible Participants who decline participation in Asthma and/or COPD Management, the Participant will continue to be responsible for any applicable deductible and cost share amounts applied to Inhaled Corticosteroids and Inhaled Anticholinergics.

**Generic Incentive Program**

Participants who are prescribed a medication that has a generic equivalent, but choose to fill the brand name, will pay the retail difference between the generic equivalent and brand name medication. The costs of a prescribed brand name medication above the generic equivalent costs are not covered expenses. These costs will not automatically process from any available FSA or HRA funds, and the Participant must pay the cost difference at the time of service. Prescriptions that are ordered Dispense as Written (DAW-1) by your provider or filled Dispense as Written (DAW-3) by your pharmacist are not subject to the generic incentive program.

**Non-Discounted Pharmacy Services (Mail or Retail)**

Participants visiting a pharmacy that does not offer a discount will have to pay the full price for the prescription at the time of service, then file a claim for reimbursement. Coverage will be provided at the out-of-network rates.

**Eligible Prescription Drugs**

Prescription drug means any medical substance, the label of which under the Federal Food, Drug and Cosmetic Act is required to bear the legend: “Caution: Federal Law prohibits dispensing without a prescription.”

MedTrak administers the pharmacy benefit under this Plan. The prescription drug plan provides preferred generic and brand name drugs which have been compared and evaluated with other brands and provide maximum quality and value.

For questions regarding coverage for specific drugs, contact MedTrak Customer Service at 1-800-771-4648 or visit the MedTrak website (www.medtrak.com).

**Drugs Not Covered**

The following prescription drugs are not Covered (unless otherwise required by the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively, the “PPACA”) and listed as a covered preventive service on www.healthcare.gov):

- anti-obesity drugs
- any prescription refilled in excess of the number of refills specified by the Doctor
- any prescription refilled more than one year from the Doctor’s original order
- biologicals, immunization agents or vaccines, unless otherwise provided as a Covered expense
- blood or blood plasma products
- charges for the administration or injection of any drug
- over-the-counter contraceptive drugs, jellies, creams, foams or devices
- drugs labeled “Caution limited by federal law to ‘investigational use’” or Experimental drugs
• Off-Label Drugs - These are FDA approved drugs used for diseases or conditions other than the ones that the FDA has approved indications for use. In certain circumstances and in the Plan’s sole discretion, the Plan may Cover off-label drugs where deemed Medically Necessary, not Experimental, and where such uses are supported by industry research and studies.

• drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes
• fertility medications
• homeopathics
• medication that is furnished or for which the cost is covered under any Workers’ Compensation or occupational disease law or any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the individual

• non-Federal Legend Drugs
• pregnancy termination drugs
• therapeutic devices and appliances
• topical fluoride products
• vitamins (except legend pre-natal, pediatric fluoride vitamins, Vitamin D and Vitamin K when prescribed by a physician for a medical condition.)

• Yohimbine ®

These examples are not intended to be all-inclusive. The Plan Administrator continues to reserve its discretion to exclude other pharmaceuticals which are not deemed to be Medically Necessary, Allowable or otherwise Covered. Thus, no inference should be drawn from the inclusion or exclusion of any specific pharmaceuticals in this section or otherwise. For drug dosing and fill requirements please contact MedTrak at 800-771-4648.

Preservation of Fertility

The Plan Covers preservation of fertility services specifically for Participants who undergo Medically Necessary cancer related treatments that may directly or indirectly cause iatrogenic infertility and

• Includes:
  ▪ Sperm cryopreservation
  ▪ Embryo cryopreservation

The Plan does not cover in vitro fertilization.

Preventive Care

The Plan provides 100% coverage for eligible preventive benefits received from Covered Providers who offer a network discount. Dollars spent towards preventive care do not count toward the Deductible, Cost Share or Annual Maximum, nor do they draw on the HRA. The Covered preventive care benefits are in compliance with PPACA and may also conform to the guidelines from the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics.

For a list of Covered preventive care benefits please reference www.healthcare.gov.

  o The Plan covers the human papillomavirus vaccine for both females and males so long as the Participant meets the criteria set forth under ACA.

  o The Plan Covers TB skin testing at 100% for in-network Covered Providers.
Private Duty Nursing
Coverage is provided for the services of a private duty Nurse on an outpatient basis only. Nursing services must be rendered by a Nurse who does not reside in the Participant’s home, or who is not a member of the Participant’s Immediate Family. To be Covered, the Doctor in charge of the case must certify that the Participant’s condition requires the requested care, which can only be provided by an RN or LPN. Private duty nursing applies only for care given in the Participant’s home and not part of the home health care agency’s plan of treatment. This benefit is limited to $5,000 per Participant per Plan year after the Deductible has been met.

Professional Services
Professional services are those services billed by a provider's office rather than by a facility. Covered professional services are:

- Office Visits - Visits made by Participants to health service providers’ offices for diagnosis, treatment, and follow-up.
- Surgical, Anesthesiology, Radiology and other ancillary services when billed by the provider’s office for services provided during an inpatient or outpatient visit.
- Inpatient Hospital Visit - A visit by a provider for Participants admitted to health facilities which provide room and board for the purpose of observation, care, diagnosis or treatment.

Prosthetics
Coverage is provided for the purchase and fitting of external prosthetic appliances which are used as a replacement or substitute for a missing body part, and are necessary for the alleviation or correction of illness, Injury, or congenital defect.

Replacement or repair, as appropriate, of external prosthetic appliances is Covered if necessitated by such circumstances as normal anatomical growth, physical changes which render the device ineffective, or excessive wear.

Coverage for internal prosthetic appliances includes the purchase, maintenance, or repair of permanent or temporary internal aids and supports for defective body parts, specifically, intraocular lenses, artificial heart valves, cardiac pacemakers, artificial joints, and other surgical materials such as screw nails, sutures and wire mesh.

Radiation Therapy
The treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes is a Covered service.

Skilled Nursing Facility
Coverage is provided for Skilled Nursing Facilities, a residential care setting offering a protective, therapeutic environment for Participants who require rehabilitative care or can no longer live independently because of a chronic physical or mental condition requiring round-the-clock skilled nursing care. Skilled Nursing Facilities must be licensed by the state and are subject to certain state and federal regulations. Skilled Nursing Facility care is limited to 60 days per Participant per Plan Year.

Covered services and supplies include semiprivate room and board, charges for other medical services and supplies, and Doctor’s services.
Surgery
Coverage is provided for surgery rendered in both Inpatient and outpatient settings for the treatment of disease or Injury. Separate payment will not be made for pre-operative care or post-operative care normally provided by the surgeon as part of the surgical procedure.

Second Surgical Opinion
Coverage is provided for an opinion provided by a second Doctor, when one Doctor recommends surgery to an individual.

Therapy Services
To be Covered, the therapy services must be rendered in accordance with a Doctor's written treatment plan.

- **Occupational Therapy** – the treatment of a physically Disabled person by means of constructive activities designed and adapted to promote the functional restoration of the person's abilities lost or impaired by disease or accidental Injury, to satisfactorily accomplish the ordinary tasks of daily living.
- **Physical Therapy** – the treatment by physical means, hydrotherapy, heat, or similar modalities; physical agents; bio-mechanical and neuro-physical principles; and devices to relieve pain, restore maximum function lost or impaired by disease or accidental Injury, and prevent Disability following disease, Injury or loss of body part.
- **Speech Therapy** - Speech therapy is Covered to restore speech loss or correct impairment due to a congenital defect, illness or Injury.

Transplant Services
Coverage is provided for the expenses for human to human organ or tissue transplants including:

- Cornea
- Liver
- Bone marrow/Stem cell
- Heart
- Lung
- Kidney/pancreas
- Liver/small bowel

Covered expenses incurred by the donor of an organ or tissue for transplant to a recipient Participant under this Plan are Covered the same as any other illness when the donor is a Participant.

Covered expenses incurred by the donor of an organ or tissue for transplant when the donor is not a Participant are Covered to the extent of any benefits remaining after payment of the Participant's expenses as a recipient, when the donor's expenses are not Covered under any group or individual insurance policy or benefit plan and are charged to the recipient.

Covered expenses include:

- Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part;
- Services and supplies furnished by a facility provider;
- Treatment and surgery by a professional provider; and
- Drug therapy treatment to prevent rejection of the transplanted organ or tissue.
Surgical, storage and transportation costs directly related to the procurement of an organ or tissue used in a transplant described above will be Covered for each such procedure completed. If an organ or tissue is sold rather than donated, no benefits will be available for the purchase price of such organ or tissue. If a Covered transplant procedure is not done as scheduled due to the intended recipient’s medical condition or death, benefits will be paid for charges incurred for organ or tissue procurement as described above.

Travel and transportation services for Participant and/or donor are not Covered.

**A Participant must contact Cerner Health Plan Services in order for care to be pre-certified prior to transplant services occurring. Services that are not pre-certified are not Covered.**

**Urgent Care Center**

Coverage is provided at an emergency medical service center, which is separate from any other hospital or medical facility.

**Wigs**

Benefits are provided when baldness is a result of chemotherapy, alopecia, radiation therapy or surgery. Wigs are limited to $300 per Participant per Plan Year.

**Services, Supplies, and Medical Expenses Not Covered**

Certain services, supplies and medical expenses are not eligible for benefits under the Plan unless otherwise addressed by the PPACA and listed as a required preventive service on www.healthcare.gov.

The following is a list of services, supplies and medical expenses that are not Covered. This list is non-exhaustive. To the extent a particular service, supply or medical expense is not specifically provided for in this Plan, such service, supply or medical expense is also not Covered.

**Services Not Covered**

- Any treatment, Confinement, or service which is not recommended by, or any operation which is not performed by, an appropriate professional provider; Examination by a Doctor, related laboratory tests, x-rays and vaccines performed in the absence of specific symptoms on the part of the Participant (except as may be specifically provided herein);
- Services performed by any person who is a member of the Participant’s Immediate Family or a person who resides in the Participant’s home;
- Acupuncture;
- Any surgical technique performed for the correction of myopia or hyperopia, including but not limited to keratomileusis, keratophakia, or radial keratotomy (plastic surgeries on the cornea in lieu of eyeglasses), and all related services;
- Artificial reproductive procedures, including but not limited to artificial insemination and in vitro fertilization, or fertility drugs when used for treatment of infertility;
- Biofeedback;
- Cosmetic procedures, unless the Participant receives an Injury which requires cosmetic surgery; or cosmetic surgery is necessary to restore impaired bodily function resulting from disease, genetic abnormality, or previous therapeutic processes;
- Custodial care, domiciliary care or rest cures;
- Exercise programs or use of exercise equipment, special diets or diet supplements, NutriSystem®, Weight Watchers® or similar programs; and hospital Confinements for weight reduction programs;
• Experimental procedures;
• Extraction of wisdom teeth;
• Genetic testing, genetic counseling and genetic therapy not needed for treatment or not a required preventive service under the ACA and listed as such on www.healthcare.gov;
• Head remodeling band for the treatment of positional non-synostotic plagiocephaly;
• Holistic and homeopathic treatment;
• Home births;
• Learning disabilities treatment, services, educational testing or associated training;
• Marriage and family counseling;
• Massage therapy not rendered by a Doctor;
• Naturopathic Services;
• Non-surgical treatment of temporomandibular joint disorders and related conditions by any method; Temporomandibular Joint Dysfunction (TMJ) Coverage is provided for surgical treatment of temporomandibular joint dysfunction if due to accident, congenital defect or developmental defect. No Coverage is provided for appliances;
• Oral surgery or dental treatment except as may be specifically provided herein;
• Reversal of a sterilization procedures (i.e., vasectomy, tubal ligation);
• Surrogate mother charges, unless the surrogate mother is eligible under the Plan at the time the services were rendered;
• Transgender surgery;
• Treatment of nicotine addiction other than tobacco cessation intervention as required by the PPACA, unless otherwise specifically provided herein;
• Treatment of sexual dysfunction not related to organic disease;
• Vision exams;
• Vocational, work hardening or training programs regardless of diagnosis or symptoms that may be present, or for non-Medically Necessary education, except as specifically provided in this Plan;
• Weight reduction (gastric bypass, lap band, etc.) surgery.

Supplies Not Covered
• Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the Participant’s condition;
• Eye refractions, eyeglasses (except when medically needed after cataract surgery), contact lenses;
• Vitamins, except those which by law require a prescription order and are prescribed to treat a specific illness or Injury, or nutritional supplements.

Medical Expenses Not Covered
• Services provided without cost by any governmental agency, except where such exclusion is prohibited by law;
• Charges for services for a Participant not Covered under the Plan at the time the service was rendered;
• Charges made for care or treatment which is not Medically Necessary;
• Charges made which are in excess of the Allowable Charges;
• Charges related to shipping and handling charges for any Covered item;
• Charges the Participant has no obligation to pay;
• For or in connection with an illness or Injury for which a Participant is eligible or covered under Workers’ Compensation or similar law;
• For or in connection with an Injury or illness arising out of, or in the course of, any employment for wage or profit;
• Injury sustained or illness contracted as the result of or caused by any act of war, or participation in a riot or civil disobedience;
• Services, treatment or supplies for which no charge would usually be made;
• Telephone consultations, charges for failure to keep a scheduled visit, charges for the copying of medical records, or charges for completion of a claim form;
• To the extent that a Participant is reimbursed or in any way indemnified for those expenses by or through Medicare or any other public program; and
• Travel and transportation services for transplants.

These examples are not intended to be all-inclusive. The Plan Administrator continues to reserve its discretion to exclude other procedures, services, or supplies relating to infertility or charges for any other condition, disease, ailment or illness which are not deemed to be Medically Necessary, Allowable or otherwise Covered. Thus, no inference should be drawn from the inclusion or exclusion of any specific condition, disease, ailment or illness, or its related treatment, diagnosis or care, in this section or otherwise.

Claims and Appeals
Covered Providers who offer a network discount will most likely take care of the claim for the Participants they treat. Participants who receive services from a Covered Provider who does not offer a Cerner network discount may have to file their own claim.

To file a claim, it’s a good idea to take the claim form along with you to the provider’s office. Participant claim forms can be obtained by contacting Cerner HealthPlan Services Customer Service at 1-877-765-1033 or by logging in to www.cernerhps.com.

Claims Procedure
To file a claim for benefits, complete the appropriate forms and mail them with all required documentation to:

Cigna
PO Box 188061
Chattanooga, TN 37422-8061

Note: If Participants are Confined in an Inpatient setting at the time of the Effective Date of the Plan, a Participant’s previous carrier will continue to be responsible for the stay until he or she is discharged or has a change in the level of care. All claims must be submitted to a Participant’s previous carrier. The Plan will administer any subsequent medical services after the Confinement.

Important: Claims should be submitted as soon as possible. Claims submitted for primary payment more than 12 months from the date of service will not be paid by the Plan.

Claims involving coordination of benefits which are submitted for secondary payment more than 12 months from the date of the primary carrier’s payment will not be paid.
Claims involving a retraction of payment by a State or Federal healthcare program submitted for payment more than 12 months from the date of retraction will not be paid.

**Note:** Covered expenses must first be submitted to Cerner HealthPlan Services for payment. Only if these expenses are not Covered are they eligible to be reimbursed from a health care flexible spending account a Participant may have. Charges not reimbursed, such as Cost Share, may be eligible for reimbursement from an employer-sponsored flexible spending account if they are not reimbursable from any other source. Generally, Cerner has delegated its Claims Administration authority for the Plan to Cerner HealthPlan Services. As the Claims Administrator, Cerner HealthPlan Services is responsible for reviewing and processing certain claims, as follows:

- Initial claim,
- First level appeals,
- All appeals involving an Urgent Care Claim, and
- All second level appeals.

<table>
<thead>
<tr>
<th>Initial Claim</th>
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<tbody>
<tr>
<td><strong>Submitting the claim</strong></td>
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<tr>
<td><strong>Approval of Claim</strong></td>
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### Denial of Initial Claim

If a claim for benefits is denied (in whole or in part) by Cerner HealthPlan Services, Cerner HealthPlan Services shall provide the Claimant with written or electronic notification of such denial. The notice of denial of the claim shall include:

- The specific reason that the claim was denied.
- A reference to the specific Plan provisions on which the denial was based.
- A description of any additional material or information necessary to perfect the claim, and an explanation of why this material or information is necessary.
- A description of the Plan's appeal procedures and the time limits that apply to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) if the claim is denied on appeal.
- Any materials required under 29 C.F.R. § 2560.503-1(g)(1)(v) (relating to claims that are denied on the basis of an internal guideline, Medical Necessity limitation, or Experimental treatment limitation).
- In the case of an Urgent Care Claim, a description of the expedited appeal procedures.

The Claimant (or his duly authorized representative) may review pertinent documents and submit issues and comments in writing to Cerner HealthPlan Services. The Claimant may appeal the denial as set forth in the next section of this procedure. **IF THE CLAIMANT FAILS TO APPEAL SUCH ACTION TO CERNER HEALTHPLAN SERVICES IN WRITING WITHIN THE PRESCRIBED PERIOD OF TIME DESCRIBED HEREUNDER, THE PLAN ADMINISTRATOR'S DENIAL OF A CLAIM SHALL BE FINAL, BINDING AND CONCLUSIVE.**

### Timing of Notice of Denial

The notice required by the previous section must be provided within the following time frames.

<table>
<thead>
<tr>
<th>Urgent Care Claim</th>
<th>Pre-Service Claim</th>
<th>Post-Service Claim</th>
</tr>
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<tbody>
<tr>
<td>No more than 72 hours after receipt of the claim by the Plan.</td>
<td>No more than 15 days after receipt of the claim by the Plan.</td>
<td>No more than 30 days after receipt of the claim by the Plan.</td>
</tr>
</tbody>
</table>

Notice of denial of an Urgent Care Claim may be provided orally within this time frame, provided that the written or electronic notice described in the previous section is provided no less than 3 days after the oral notification.

### Special Rule for Concurrent Care Claims.

The Claimant must submit a request to extend an ongoing course of treatment at least 24 hours before the end of the previously approved limit. If the Claimant’s request for extension is made in a timely manner and involves urgent care, Cerner HealthPlan Services will notify the Claimant of the determination, whether
adverse or not, within 24 hours after the claim is received. If the Claimant’s initial claim is not made at least 24 hours before the end of the previously approved limit, the request will be treated as an Urgent Care Claim (not a concurrent care claim) and decided according to specified timeframes (see Urgent Care Claims).

A request to extend coverage that does not involve urgent care will be considered a new claim and will be decided according to the post-service or pre-service timeframes described previously, whichever applies.

If continued coverage for a previously approved, ongoing course of treatment is cut short, Cerner HealthPlan Services will notify the Claimant sufficiently in advance to allow the Claimant to submit an appeal.

Notices regarding denials of Concurrent Care Claims will include the same information specified for initial claim denials (see “Denial of Initial Claim,” above).

**Appeal Procedures**

<table>
<thead>
<tr>
<th>First Appeal</th>
<th>General Appeal Procedure</th>
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<tr>
<td>In the event that a claim is denied (in whole or in part), the Claimant may appeal the denial by giving written notice of the appeal to Cerner HealthPlan Services within 180 days after the Claimant receives the notice of denial of the claim. At the same time the Claimant submits a notice of appeal, the Claimant may also submit written comments, documents, records, and other information relating to the claim.</td>
<td>Representatives of the Plan may hold a hearing or otherwise ascertain such facts as it deems necessary and shall render a decision which shall be binding upon both parties. In deciding the First Appeal:</td>
</tr>
<tr>
<td>• No deference shall be given to the decision denying the initial claim.</td>
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</tr>
<tr>
<td>• The appeal shall be decided by an individual who did not decide the initial claim, and who is not a subordinate of anyone that decided the initial claim.</td>
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</tr>
<tr>
<td>• The individual deciding the appeal will review and consider the information submitted by the Claimant, without regard to whether the information was submitted or considered in conjunction with the initial claim.</td>
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</tr>
<tr>
<td>• If the appeal decision is based in whole or in part on a medical judgment, the individual deciding the appeal shall consult with a health care professional who has appropriate training and experience in the relevant field. The health care professional must not be an individual who participated in the denial of the initial claim, and must not be the subordinate of any such individual.</td>
<td>• If the appeal decision is based in whole or in part on a medical judgment, the individual deciding the appeal shall consult with a health care professional who has appropriate training and experience in the relevant field. The health care professional must not be an individual who participated in the denial of the initial claim, and must not be the subordinate of any such individual.</td>
</tr>
<tr>
<td>• If Representatives of the Plan obtained advice from any medical or vocational experts in conjunction with the initial claim, then such experts must be identified to the Claimant. This identification must occur even if Representatives of the Plan did not rely on the advice obtained.</td>
<td>• If Representatives of the Plan obtained advice from any medical or vocational experts in conjunction with the initial claim, then such experts must be identified to the Claimant. This identification must occur even if Representatives of the Plan did not rely on the advice obtained.</td>
</tr>
</tbody>
</table>
### Special Appeal Procedure for Urgent Care Claims

In addition to the procedures set forth in the preceding section, the following shall apply to the appeal of an Urgent Care Claim:

- A request for expedited review must be made to Cerner HealthPlan Services, but may be made either orally or in writing.
- All necessary information will be transmitted from the Plan to the Claimant by telephone, facsimile or similarly expeditious means.
- Claimant may also want to consider a request for an expedited External Review, as discussed below.

### Notice of Decision on Appeal

The appeal decision of Representatives of the Plan shall be provided in written or electronic form to the Claimant. If the appeal decision is adverse to the Claimant, then the written decision shall include the following:

- The specific reason or reasons for the appeal decision.
- Reference to the specific Plan provisions on which the appeal decision is based.
- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. (Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to 29 C.F.R. § 2560.503-1 (m)(8).)
- A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures.
- A statement of the Claimant's right to bring an action under Section 502(a) of the Employee Retirement Income Security Act.
- Any materials required under 29 C.F.R. § 2560.503-1(jj)(5)(i) or (ii) (relating to claims that are denied on the basis of an internal guideline, Medical Necessity limitation, or Experimental treatment limitation).
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
### Timing of Notice of Decision on Appeal

Representatives of the Plan shall render a decision on appeal within the following time frames, unless special circumstances require an extension of time. (See procedures concerning extensions of time.)

- For an Urgent Care Claim – no more than 72 hours after receipt of the appeal by the Plan.
- For a Pre-Service Claim – with respect to any one of two appeals, no more than 15 days after receipt of the claim by the Plan.
- For a Post-Service Claim – with respect to any one of two appeals, no more than 30 days after receipt of the claim by the Plan.

### Second Appeal

In the event that the First Appeal is denied (in whole or in part), the Claimant may appeal further by giving written notice of the appeal to the Representatives of the Plan within a reasonable period of time after the Claimant receives the notice of denial of the First Appeal. At the same time the Claimant submits a notice of Second Appeal, the Claimant may also submit written comments, documents, records, and other information relating to the claim.

### General Appeal Procedure

Representatives of the Plan may hold a hearing or otherwise ascertain such facts as it deems necessary and shall render a final decision which shall be binding upon both parties. In deciding the Second Appeal:

- No deference shall be given to the decision denying the claim or First Appeal.
- The Second Appeal shall be decided by an individual who did not decide the claim or the First Appeal, and who is not a subordinate of anyone that decided the claim or First Appeal.
- The individual deciding the Second Appeal will review and consider the information submitted by the Claimant, without regard to whether the information was submitted or considered in conjunction with the claim or First Appeal.
- If the Second Appeal decision is based in whole or in part on a medical judgment, the individual deciding the appeal shall consult with a health care professional who has appropriate training and experience in the relevant field. The health care professional must not be an individual who participated in the denial of the initial appeal, and must not be the subordinate of any such individual.
### Special Appeal Procedure for Urgent Care Claims

In addition to the procedures set forth in the preceding section, the following shall apply to the appeal of an Urgent Care Appeal:

- A request for expedited review must be made to Representatives of the Plan, but may be made either orally or in writing.
- All necessary information will be transmitted from the Plan to the Claimant by telephone, facsimile or similarly expeditious means.

### Notice of Decision on Appeal

The decision on Second Appeal shall be provided in written or electronic form to the Claimant. If the Second Appeal decision is adverse to the Claimant, then the written decision shall include the following:

- The specific reason or reasons for the Second Appeal decision.
- Reference to the specific Plan provisions on which the Second Appeal decision is based.
- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. (Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to 29 C.F.R. § 2560.503-1 (m)(8).)

Any materials required under 29 C.F.R. § 2560.503-1(j)(5)(i) or (ii) (relating to claims that are denied on the basis of an internal guideline, Medical Necessity limitation, or Experimental treatment limitation).

### Timing of Notice of Decision on Appeal.

Representatives of the Plan shall render a decision on a Second Appeal decision within the following time frames, unless special circumstances require an extension of time. (See procedures concerning extensions of time.)

- For an Urgent Care Claim – no more than 72 hours after receipt of the appeal by the Plan.
- For a Pre-Service Claim – no more than 15 days after receipt of the appeal by the Plan.
- For a Post-Service Claim – no more than 30 days after receipt of the appeal by the Plan.
## Extension of Time

**Extension of Time**

Extensions of time are available, subject to the following limitations:

- **For an initial Urgent Care Claim** – If the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are Covered under the Plan, Representatives of the Plan shall notify the Claimant, within 24 hours of receipt of the appeal, of the specific information necessary to complete the appeal. The Claimant shall be permitted not less than 48 hours to provide the specified information. Representatives of the Plan shall notify the Claimant of a grant or denial of the appeal within 48 hours after the earlier of: (a) the end of the time period given to the Claimant to provide the specified information or (b) the Plan's receipt of the specified information.
- **For an initial Pre-Service Claim** – No more than one extension of 15 days.
- **For an initial Post-Service Claim** – No more than one extension of 15 days.

### Notice of Extension

If the Representatives of the Plan require an extension of time, the Representatives of the Plan shall provide the Claimant with written or electronic notice of the extension before the first day of the extension. The notice of the extension shall include:

- An explanation of the circumstances requiring the extension. These circumstances must be matters beyond the control of the Plan or the Representatives of the Plan.
- The date by which the Administrator or Representatives of the Plan expect to render a decision.
- The standard on which the Claimant's entitlement to a benefit is based.
- The unresolved issues, if any that prevent a decision on the appeal and the information needed to resolve those issues. In the event that such information is needed:
  - The Claimant shall have at least 10 days in which to provide the specified information.
  - The time for determining an initial claim shall be tolled from the date on which the notice of extension is sent to the Claimant, until the date on which the Claimant responds to the request for additional information.
## EXTERNAL REVIEW

### Requesting External Review

In the event that a Second Appeal results in an adverse benefit determination (in whole or in part), the Claimant may request an External Review by giving written notice of the appeal to Cerner HealthPlan Services within 120 days after the Claimant receives the notice of Decision on the Second Appeal.

### Eligibility for External Review

Within 5 business days following the date of receipt of the External Review request, Cerner HealthPlan Services will complete a preliminary review of the request to determine whether the matter is eligible for External Review. A matter is eligible for External Review only if all of the following are TRUE:

- The Claimant is or was covered under the Plan at the time the health care item or service was requested;
- The denial does not relate to the Claimant’s failure to meet the eligibility requirements under the terms of the Plan (in other words, the External Review process does not apply to eligibility determinations);
- The Claimant has exhausted the Plan’s internal appeal process; and
- The Claimant has provided all the information required to process an External Review.

Within 1 business day after completion of the preliminary review, Cerner HealthPlan Services will issue a notification in writing to the Claimant. The notification will advise Claimant that:

- The claim is not eligible for External Review;
- The claim is eligible and ready for External Review; or
- It is unclear whether the claim is eligible for External Review because Claimant has not provided all the information required.

### External Review Process

If the claim is eligible and ready for External Review, Cerner HealthPlan Services will assign an Independent Review Organization (“IRO”) that is accredited by URAC (a nonprofit organization promoting health care quality by accrediting health care organizations) or by a similar nationally recognized accrediting organization to conduct the external review.

The IRO will timely notify the Claimant in writing of the request’s eligibility and acceptance for External Review, including a statement that the Claimant may submit in writing, within 10 business days, additional information which the IRO must then consider when conducting the External Review; and

Within 5 business days after the date of assignment to the IRO, Cerner HealthPlan Services will provide the IRO the documents and any information considered in deciding the Initial Claim, the First Appeal, and the Second Appeal.
Within 45 days after it receives the request for External Review, the IRO will deliver a notice of decision to Claimant.

| Expedited External Review | Claimant may request an “expedited” External Review if: Claimant (a) has received a decision on an initial claim involving either urgent care or concurrent care, (b) has filed a request for an Appeal, and (c) has a medical condition for which the timeframe for completion of an Appeal would seriously jeopardize Claimant’s life or health or would jeopardize Claimant’s ability to regain maximum function; or Claimant (a) has completed a first and second Appeal, and (b) has a medical condition for which the timeframe a standard External Review would seriously jeopardize Claimant’s life or health, would jeopardize Claimant’s ability to regain maximum function; or Claimant (a) has completed a first and second Appeal, (b) has appealed a claim that concerns an admission, availability of care, continued stay, or health care item or service for which Claimant received emergency services, and (c) has not been discharged from the facility.
A request for an expedited External Review must be accompanied by a written statement from Claimant’s physician that Claimant’s medical condition meets the criteria above.

The IRO will provide notice of its decision on an expedited External Review as expeditiously as Claimant’s medical condition or circumstances require, but in no event more than 72 hours after the IRO’s receipt of Claimant’s request. If the notice is not in writing, the IRO will provide written notice to Claimant within 48 hours after its decision.

Questions about Benefit Determinations
Participants with questions or concerns about a benefit determination may informally contact Cerner HealthPlan Services member service before requesting a formal appeal. If the member service representative cannot resolve the issue to a Participant’s satisfaction over the phone, he/she may submit his/her questions in writing. Participants not satisfied with a benefit determination may appeal it immediately as described above, without first informally contacting customer service.

Leaving the Plan and When Coverage Ends
Subject to a Participant’s right to elect continuation coverage, benefit coverage for a Participant will end upon the earliest of the following events:

- the Participant experiences a Change in Status or Qualifying Event and opts out of the Plan,
- the Covered Dependent(s) no longer qualify as a Dependent(s) under the Plan, either through a Plan amendment or otherwise,
- Cerner discontinues the Plan,
- the Subscriber is no longer eligible under the Plan, either through a Plan amendment or otherwise,
- a Participant fails to make required contributions for coverage,
- a Participant’s coverage ends for any reason,
- a Subscriber terminates employment with Cerner for any reason, or
- any other disqualifications for benefits.
In most cases coverage will terminate as of midnight on the date that the Participant is no longer in an eligible class. Benefit coverage for an Associate’s Dependents will terminate upon the termination of the coverage for the Associate. If the Subscriber is on an approved leave of absence from Cerner, and such leave is consistent with the Family and Medical Leave Act, other law, or Cerner’s Leave of Absence Policy such Subscriber may be able to continue coverage.

If it is determined that a Participant is ineligible for coverage under the Plan and the Participant’s coverage was a result of fraud or an intentional misrepresentation of material fact, such coverage will be terminated, following a 30-day notice period, as of the date of the Plan Administrator’s request or the date of ineligibility, whichever comes first.

Conversion of Coverage

Coverage may not be converted to an individual plan upon termination of employment. For continuation of the Plan, refer to the Section entitled Right to Purchase Continuation Coverage below.

Right to Purchase Continuation Coverage

If a Participant loses coverage under the Plan, such Participant may have the right to COBRA continuation coverage. Associates should have received a statement regarding their rights to COBRA continuation coverage in certain circumstances. To request an additional copy of a statement regarding a Participant’s rights to COBRA continuation coverage, contact the Cerner Benefits Administrator or see the Wraparound Benefits Plan Document and SPD.

Coordination of Benefits (COB)

If the Participant has other medical coverage, benefits under this Plan are coordinated with benefits under any such other plan to avoid duplication of payment. The two plans together will not pay more than 100% of Covered expenses.

For purposes of this Coordination of Benefits (“COB”) section:

Plan means any of the following, if medical benefits or services are provided:

- Coverage for persons in a group whether on an insured or uninsured basis, including, but not limited to, a plan or policy through a health maintenance organization, medical care corporation, health care corporation or hospital service corporation;
- Student coverage sponsored by or provided through an educational institution;
- Coverage under a governmental plan, except Medicaid; or
- Coverage which is mandated by state or federal statute, excluding Workers’ Compensation.

The term plan shall be construed separately with respect to each policy, contract or other arrangement for benefits or services described above. If any such policy, contract or other arrangement has two parts and COB rules apply only to one of the two, each of the two parts is a separate plan.

Primary or primary plan means the plan which pays benefits first according to this Plan's order of benefit determination.

Secondary or secondary plan means a plan that is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules of this Plan will decide the order in which their benefits are determined in relation to each other.

This Plan means that portion of this Healthe Options Component Plan that provides medical benefits that may be reduced because of the benefits from other plans.
How COB Works
Under COB provisions, one group plan has “primary” responsibility and pays first. The other group plan has “secondary” responsibility and considers any additional benefits not covered by the primary carrier. Therefore, if this Plan is:

- **primary**—it pays expenses as if no other insurance were involved.
- **secondary**—it pays benefits only if the Participant has not already received the full amount this Plan would pay if it were primary.

<table>
<thead>
<tr>
<th>If the benefit is for ...</th>
<th>Then ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>An Associate</td>
<td>This Plan is primary</td>
</tr>
<tr>
<td>A COBRA Participant</td>
<td>This Plan is the secondary payer if the Participant is covered through another plan</td>
</tr>
<tr>
<td>A Spouse or Domestic Partner</td>
<td>This Plan is always the secondary payer if he/she is covered through another plan</td>
</tr>
<tr>
<td>A Covered Eligible Dependent other than your Spouse or Domestic Partner</td>
<td>The primary plan is determined by the COB “Birthday Rule”</td>
</tr>
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</table>

If the other plan does not have a COB provision, these rules will not apply. In that case, the other plan is automatically primary.

If a Participant is continuing coverage under COBRA under this Plan and the Participant is covered under more than one plan, this Plan deems that the COBRA coverage will pay last.

A Participant should always file a claim with the primary plan first and then submit a copy of what the primary plan has paid or denied (along with copies of the same itemized expenses) to the secondary plan. This will avoid delays in claims processing and will ensure that the Participant is reimbursed for the full amount to which he/she is entitled.

COB “Birthday Rule”
Under this rule, primary coverage for a Subscriber’s Covered dependent children will be the plan of the parent whose birthday occurs first in the calendar year. For example, if the Spouse or Domestic Partner’s birthday is in March and the Associate’s birthday is in October, the Spouse or Domestic Partner’s plan will provide primary coverage for the Associate’s Covered children. If a decision cannot be made based on the birthday rule, the plan that has covered the individual the longest will be primary.

Primary coverage for a dependent child whose parents are separated or divorced will be determined in the following order, without regard to the birthday rule:

1. The plan of the parent with custody of the child.
2. The plan of the stepparent whose Spouse or Domestic Partner has custody of the child—if the parent with custody has remarried.
3. The plan of the parent not having custody of the child.

**Note:** If a court decree declares one parent responsible for a child’s medical care expenses, payment will be made first under that parent’s plan.

Coverage for the child of parents who live together but who have never married is determined in the same way as for a child whose parents are married, and the "birthday rule" determines the order of payment.
If the order specified above does not apply in a particular case, the plan Covering the Participant for the longer period of time is deemed by this Plan to be primary over the plan covering the Participant for the shorter term. To determine the length of time a Participant has been Covered under a plan, two plans shall be treated as one plan if the claimant was eligible under the second plan within 24 hours after the first plan ended. The claimant's length of time covered under a plan is deemed to begin on the first day of the claimant's coverage under that plan.

**Integrating Benefits with Medicare**

If a Participant is eligible for benefits under Medicare, a Participant's benefits under this Plan are dependent upon which coverage is "primary."

For more information please review the publication “Medicare and other Health Benefits – Your Guide to Who pays first” at [www.medicare.gov](http://www.medicare.gov).

**Right to Recovery, Reimbursement, Subrogation and Set-off**

**Corrective Payments**

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

**Reimbursement**

Whenever this Plan makes payments which together with the payments the Participant has received or is entitled to receive from any other plan or person, exceed the maximum amount necessary to satisfy the intent of this provision, or exceed, under the terms of this Plan, the benefits properly payable to the Participant, plan, provider or person to or for or with respect to whom the payments were made, this Plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Plan Administrator in its sole discretion shall determine:

- The Associate;
- If the individual is a Dependent or former Dependent, the Associate or former Associate with respect to whom the individual is or was an Dependent;
- The Participant;
- Any other plan, provider or person to or for or with respect to whom such payments were made;
- Any insurance company or other plan or person which should have made the payment;
- Any other organizations.

Alternatively, the Plan Administrator or its designee may set-off the amount of such payments, to the extent of such excess, against any amount owing, at that time or in the future, under this Plan to one or more of the Associates, Participants, plans, persons, providers, insurance companies or other organizations as listed above.

For example, but not by way of limitation, if this Plan pays a claim submitted by a Participant or by a health care provider who treated the Participant, and the Plan Administrator or its designee later determines that the claim was for an expense not Covered under this Plan, this Plan is entitled to recover the payment from the Participant or the provider, or to recover part of the payment from the Participant and part from the provider, or set-off the amount of the payment from amounts this Plan may owe in the future to the Participant or the provider, or both. This same rule applies if this Plan makes payment to a Participant or a provider of an expense which is a Covered expense, but the amount so paid exceeds the amount this Plan requires be paid.
These reimbursement provisions also apply where this Plan makes payments of Covered expenses incurred for treatment of a Covered Injury or illness for which another plan or person (or organization) is or may be liable, and where this Plan's subrogation provisions do not provide this Plan with a right to recover amounts this Plan pays or may pay for treatment of the Covered Injury or illness. If the other plan or person makes payment to or on behalf of a Participant as compensation for the Covered Injury or illness, and this Plan is not subrogated with respect to the payment, this Plan is entitled to a specific and first right of reimbursement from the Participant (or anyone who received such payment on behalf of the Participant) out of the proceeds of any settlement, judgment or other payment by another plan or person to a Participant in an amount equal to the lesser of the benefits paid by this Plan for treatment of the Covered Injury or illness, or the amount paid to or on behalf of the Participant by the other plan or person or its insurer, even if the Participant is not paid for all of the damages claimed or if the payment received is for damages other than medical expenses.

This provision shall not apply where the other plan is a medical plan with respect to which this Plan, pursuant to its coordination of benefits provisions, is the primary payer of the Participant's Covered expenses.

These reimbursement provisions shall not be construed to prevent the Plan, in its sole discretion, from obtaining full reimbursement from the Participant (or, in the Plan's sole discretion, any other person who received payment on behalf of the Participant, such as a parent or guardian) by, for example, apportioning the obligation to reimburse the Plan among the Associate, Participant and any other person, such as the Participant's legal counsel. The preceding sentence is specifically intended to avoid requiring the Plan, in order to obtain full reimbursement, to seek reimbursement from any person (such as the Participant's legal counsel) other than the Participant (or the person, such as a parent or legal guardian, who received payment on behalf of the Participant) where the Plan can be made whole entirely from amounts actually received by the Participant (or the person, such as a parent or legal guardian, who received such amounts on behalf of the Participant). This same rule shall apply to the Plan's rights to set-off as described above.

In addition, where another plan or person pays compensation to or on behalf of a Participant for a Covered Injury or illness for which another plan or person is or may be liable, and the Participant incurs (either before or after payment of such compensation) otherwise Covered expenses for treatment of the Covered Injury or illness, a special rule applies. In such a case, such otherwise Covered expenses which were incurred after the date on which the compensation was paid, or which were incurred before such date but not paid by the Plan as of such date, shall be excluded from coverage under the Plan to the extent of the excess (if any) of the compensation received by or on behalf of the Participant, over the Covered expenses which the Plan has already paid for treatment of the Covered Injury or illness.

This Plan shall not be responsible for any costs or expenses (including attorneys' fees) incurred by or on behalf of a Participant in connection with any recovery from any other plan or person unless this Plan agrees in writing to pay a part of those expenses. The characterization of any amounts paid to or on behalf of a Participant, whether in a settlement agreement or otherwise, shall not affect this Plan's right to reimbursement and to characterize otherwise covered charges as excludable Covered expenses pursuant to these provisions.

Subrogation

The Plan shall be subrogated, to the extent of benefits paid or payable by this Plan, to any monies (i.e., "first dollar" monies) paid or payable by any other plan or person by reason of the Covered Injury or illness which occasioned or would occasion the payment of benefits by this Plan, whether or not those monies are sufficient to make whole the Participant to whom or on whose behalf this Plan made its payments or to whom or on whose behalf this Plan's payments are payable. The Plan shall not be responsible for any costs or expenses, including attorneys' fees, incurred by or on behalf of a Participant in connection with any efforts to recover monies from any other plan or person, unless this Plan agrees in writing to pay a portion of those expenses. The characterization of any amounts paid to or on behalf of a Participant, whether under a settlement agreement or otherwise, shall not affect this Plan's right to subrogation and to claim, pursuant to such right, all or a portion of such payment.
These subrogation provisions shall not be construed to prevent the Plan, in its sole discretion, from obtaining full satisfaction of its subrogation lien from the Participant (or, in the Plan's sole discretion, any other person who received payment on behalf of the Participant, such as a parent or guardian) by, for example, apportioning liability for satisfaction of the subrogation lien among the Participant and any other person, such as the Participant's legal counsel.

This Plan shall be subrogated to any and all rights of recovery and causes of action which the Participant may have against any liable plan or person. This Plan shall also be subrogated to the extent of benefits paid under this Plan to any claim a Participant may have against any other plan or person for the Covered Injury or illness which occasioned the payment of benefits under this Plan. Upon written notification to the Participant, this Plan may (but shall not be required to) collect the claim directly from the other plan or person in any manner this Plan chooses without the Participant's consent. This Plan shall apply any monies collected from the other plan or person to payments made under this Plan and to any reasonable costs and expenses (including attorneys' fees) incurred by this Plan in connection with the collection of the claim up to the amount of the award or settlement. Any balance remaining shall be paid to the Participant as soon as administratively practical. The Plan Administrator may, within its sole discretion, apportion the monies such that this Plan receives less than full reimbursement.

This Plan, once it pays benefits occasioned by any Covered Injury or illness to the Participant for which another plan or person is liable, is granted an equitable lien or constructive trust on the gross specified funds paid to the Participant from such other plan or person, or any payment, settlement or judgment received as a result of a claim against that other plan or person, in an amount equal to the lesser of the benefits paid by this Plan for treatment of the Covered Injury or illness, or the amount paid to or on behalf of the Participant by the other plan or person or its insurer, even if the Participant is not paid for all of the damages claimed or if the payment received is for damages other than medical expenses.

This Plan's right to subrogation and reimbursement will not be affected, reduced, or eliminated by any legal doctrine, including the “Make Whole Doctrine,” comparative fault or regulatory diligence or the “Common Fund Doctrine.”

**Implementation**

The Plan Administrator shall determine which of the Plan's rights and remedies is within the best interests of this Plan to pursue. The Plan Administrator may agree to recover less than the full amount of excess payments or to accept less than full reimbursement if (i) this Plan has made, or caused to be made, such reasonable, diligent and systematic collection efforts as are appropriate under the circumstances; and (ii) the terms of such agreement are reasonable under the circumstances based on the likelihood of collecting such monies in full or the approximate expenses this Plan would incur in an attempt to collect such monies.

Where this Plan is entitled to reimbursement or subrogation under the provisions of this section, the Plan shall be permitted to obtain reimbursement or satisfy its subrogation lien by reducing benefits payable to the Associate, Participant and/or, in the Plan's discretion, any Dependent, for Covered expenses then incurred but not yet paid, and for Covered expenses incurred in the future.

**Subrogation/Reimbursement Agreement**

Except as otherwise provided herein, if a Participant incurs a Covered Injury or illness under circumstances where compensation may be payable to the Participant by some other plan or person, the Plan is not required to pay benefits for treatment of the Covered Injury or illness (notwithstanding any other provision of this Plan to the contrary), but may agree to pay benefits for that Covered Injury or illness to the extent otherwise payable under the Plan. As a condition of paying such benefits, the Plan may (but is not required to) require the Participant or someone legally qualified and authorized to act for the Participant in writing, to:

- Consent to the Plan's subrogation of any recovery or right of recovery the Participant has with respect to the Covered Injury or illness;
- Consent to granting this Plan a constructive lien or equitable lien on any specified funds received as a result of any claim against another plan or person;

Human Resources
• Promise not to take any action which would prejudice the Plan’s subrogation rights;
• Promise to reimburse the Plan for any such benefits payments to the extent that the Participant receives a recovery from another plan or person, irrespective of how the recovery is made or characterized, and irrespective of whether the recovery is sufficient to make the Participant whole, in an amount equal to the lesser of the benefits paid by this Plan for treatment of the Covered Injury or illness, or the amount paid to or on behalf of the Participant by the other plan or person or its insurer, even if the Participant is not paid for all of the damages claimed or if the payment received is for damages other than medical expenses. This reimbursement must be made within 30 days after the Participant (or anyone on his or her behalf) receives the payment;
• Promise to cooperate fully with the Plan in asserting its subrogation rights and supply the Plan with any and all information and execute any and all forms the Plan may need for this purpose; and
• Promise not to assign any rights or cause of action that the Participant may have against another plan or person to recover medical expenses without express written consent of this Plan.

In the event the Participant fails to, or refuses to execute whatever assignment, form or document requested by the Plan Administrator or its designee, the Plan shall be relieved of any and all legal, equitable or contractual obligation for any benefits or Covered expense incurred by the Associate and his or her Dependents, including claims then incurred but unpaid.

Nothing in this reimbursement agreement provision shall be construed to prevent application of the provisions of the reimbursement provisions above, regarding the Plan’s exclusion of otherwise Covered expenses which have not been paid at the time the Participant receives compensation for the Covered Injury or illness which gave rise to the expenses.

Constructive Trust or Equitable Lien

In the event the Plan, pursuant to these reimbursement and subrogation provisions, is entitled under such provisions to be reimbursed for benefits it has paid for treatment of a Participant’s Covered illness or Injury, and where the Participant or someone (including an individual, estate or trust) on behalf of the Participant receives or is entitled to receive compensation for such Covered illness or Injury from some other source, the Plan shall have a constructive trust or equitable lien on such compensation or those specified funds recovered from another plan or person by the Participant to the extent of the benefits paid by this Plan. Such constructive trust or equitable lien shall be imposed upon the person or entity then in possession of such compensation.

Hold Account

If there is a dispute in the amount owed the Plan by a Participant, the Participant shall hold the gross of any specified funds received from another plan or person in an interest bearing account distinct from the Participant’s assets until the resolution of the dispute. Upon resolution of the dispute, the Plan shall have a constructive trust or equitable lien upon all of the funds owed to it from the Participant or other plan or person.

Other Plan Information

Payment When a Participant is Incompetent

If a Participant is legally, physically or mentally incapable of receiving benefits, the Plan Administrator may make payment to another person or institution determined to maintain or have custody of the Participant.

Amendment to or Termination of the Plan

Any increase in coverage (because of a Plan amendment or change in eligibility) or the addition of a new benefit will take effect on the effective date of the increase. Any decrease in coverage or deletion of a benefit takes effect on the effective date of the decrease or deletion for the Participant, whether or not such Participant is Actively at Work.
Cerner may amend the Plan in order to add or delete any Plan benefit, implement Associate contributions or change the amount or percentage of any required Associate contributions, or otherwise change the terms of the Plan at any time without prior notice to the Participant, unless the amendment materially affects collectively bargained terms. However, to the extent the Plan implements a mid-year material modification of Plan terms affecting the content of the Summary of Benefits and Coverages of the Plan, notice of such modification will be provided 60 days in advance of the effective date of the change.

Although it is Cerner's intention that this Plan continue, Cerner reserves the right to terminate the Plan at any time without the consent of or advance notice to Participants.

Definitions

**Actively at Work**
Performing all of an Associate’s customary duties of employment with Cerner for which the Associate is receiving regular earnings from Cerner, either at the Associate’s usual place of employment or at a location to which the business of Cerner requires the Associate to travel, except that (i) an Associate is deemed actively at work on each day of regular paid time off or on a regular nonworking day, provided the Associate was actively at work on the last preceding regular working day and (ii) an Associate is deemed actively at work on each day that the Associate is absent from work due to a physical or mental health condition.

**Allowable Charge**
The Center for Medicare and Medicaid Services (CMS) creates Medicare fee schedules for physician services, non-emergent ambulance services, clinical laboratory services, durable medical equipment, prosthetics, orthotics, and supplies. For Covered services rendered by an out-of-network provider prior to June 1, 2016, the Allowable Charges will be 100% of the amount established by the most recently released and applicable Medicare fee schedule for Metropolitan Kansas City, Missouri. For Covered services rendered by an out-of-network provider on or after June 1, 2016, the Allowable Charges will be 100% of the amount established by the most recently released and applicable regional Medicare fee schedule for the geographic area in which the service is provided.

For Covered services, rendered by an out-of-network provider, that are not included in the applicable Medicare fee schedule, the allowable amount will be 65% of the total billed charges.

The allowable charges for Emergency services, including emergent ambulance services, rendered by out-of-network providers, will be 100% of billed charges.

Cerner has chosen the foregoing as the basis for determining Allowable Charges in an effort to promote price transparency for Participants; Participants who need assistance in determining the Allowable Charge for a particular Covered service are encouraged to call Cerner HealthPlan Services.

**Associate**
A person employed by Cerner.

**Birthing Facility**
A facility operated by a hospital or other licensed health care institution for the purpose of providing an alternative environment for childbirth other than the hospital delivery or operating room.

**Claims Administrator or Cerner HealthPlan Services**
Organization contracted by Cerner (i.e., The Health Exchange, Inc. d/b/a Cerner HealthPlan Services) who provides administrative services under this Plan.
**Concurrent Care Claim**
Includes (i) a claim to extend coverage for a course of treatment beyond a previously approved period of time or number of treatments, or (ii) a claim regarding reduction or termination of coverage by the Plan before the end of a previously approved period of time or number of treatments.

**Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**
A federal law that enables Participants to continue coverage under this Plan in the event that he/she loses coverage as the result of certain qualifying events.

**Cerner or Employer**
Cerner Corporation and all Participating Employers duly adopting the Plan.

**Code**
The Internal Revenue Code of 1986, as amended.

**Confinement or Confined**
Registered as a bed patient.

**Cosmetic Procedure**
A procedure done for the improvement of a Participant’s appearance rather than improvement or restoration of bodily function.

**Covered**
When modifying person, Associate, Spouse, Domestic Partner or Dependent, means eligible and enrolled for coverage in accordance with all the terms of the Plan. When modifying services, charges, expenses, Injury, illness or any word that describes an Injury or illness, it means payable under the terms and conditions of the Plan.

**Covered Providers**
Medical benefits extend to Covered services provided by licensed providers as follows:

- Doctors (as defined below)
- Osteopaths
- Podiatrists
- Physical and occupational therapists
- Speech therapists
- Licensed clinical psychologists
- Nurses

Provided they:

- Practice within the scope of their license,
- Practice within the scope of generally accepted medical practices, and
- Are recognized by the state in which they practice.

Licensed clinical social workers and licensed marriage, family and/or child counselors are also Covered. They must either:

- Be licensed or certified by the appropriate governmental authority having jurisdiction over such licensure or certification in the jurisdiction where the provider renders service, or
• Be a member or fellow of the American Psychological Association if there is no licensure or certification in the jurisdiction where that provider renders service.

Providers who are professionally registered in their state, but do not meet the above listed criteria will not be Covered.

**Custodial Care**

Care given primarily to assist a Participant in the activities of daily living or routine maintenance or supportive care which need not be provided in an institutional setting by skilled professional personnel, including but not limited to:

• preparation of special diets;
• supervision over medication that can be self-administered; and
• assisting the person in getting in or out of bed, walking, eating, dressing, bathing or using the toilet.

**Disability or Disabled**

A condition due to illness or Injury unrelated to employment or self-employment which requires regular medical care under the direction of a medical Doctor (MD) or osteopath (DO) and:

• in the case of an Associate, renders the Associate unable to engage in any and every duty pertaining to the Associate's employment; and,

• in the case of a Covered Dependent, renders the Dependent unable to engage in all the normal activities of a person of like age and sex who is in good health.

**Doctor**

Means a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatry (DPM), Doctor of Chiropractic (DC), Doctor of Dental Surgery (DDS) or any other licensed or certified practitioner providing a service Covered under the Plan who is duly licensed, certified, or otherwise authorized under the law of applicable jurisdiction to practice within the scope of his or her specialty (see list below). The definition of "Doctor" excludes a member of the Participant's Immediate Family or a person residing in the Participant's home.

Licensed or certified practitioners who meet the definition of Doctor include:

• Audiologist
• Certified Nurse Anesthetist
• Certified Registered Nurse Anesthetist (CRNP)
• Certified Nurse Midwife (CNM)
• Certified Nurse Practitioner (CNP)
• Certified Doctors' Assistant (PA-C)
• Licensed/Certified Professional Counselor
• Licensed Professional Physical Therapist
• Occupational Therapist
• Optometrist (OD)
• Physiotherapist
• Psychiatrist
• Clinical Psychologist (Ph.D., Ed.D, Psy.D)
• Speech Language Pathologist

**Effective Date**
The first day an Associate or Dependent becomes a Participant under the Plan.

**Employee Retirement Income Security Act of 1974 (ERISA)**
A federal law that provides certain rights and protections to which Participants are entitled. The act imposes duties upon the people who operate employee benefit plans, to do so prudently and in the best interest of employees and other Plan Participants and beneficiaries.

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

The Plan Administrator has the discretion to make an independent evaluation of the Experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The Plan Administrator will be guided by the following principles:

- The technology must be appropriate, in level of service and intensity, to the nature of the disease or condition being treated.
- Public policy would support the procedure(s) as a valid and ethical course of treatment.
- The technology is judged to be reasonably clinically effective according to reports in peer reviewed scientific literature, completed clinical study data and/or preponderant expert medical opinion.

If technology does not meet the above criteria, in whole or in significant part, it will be deemed Experimental. The decisions of the Plan Administrator will be final and binding on the Plan.

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

The fact that an Experimental service or an unproven or investigational service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered unproven or investigational in the treatment of that particular condition.

**Federal Legend Drug**
A drug which is required under Federal law to be labeled with either of the following statements prior to being dispensed or delivered: (i) "Caution: Federal law prohibits dispensing without prescription"; (ii) "Caution: Federal law restricts this drug to use by, or on the order of, a licensed veterinarian"; or a drug which is required by any applicable Federal or State law or rule to be dispensed pursuant only to a prescription drug order or is restricted to use by Doctors only.

**Health Reimbursement Account (HRA)**
A personal account established in the name of each Associate who participates in the Plan. Money in the account may be used to pay expenses for the Deductible, the Cost Share portion of the Plan, and IRS Qualified Medical Expenses.
**Immediate Family**
A parent, Spouse, Domestic Partner, sibling or child (including Spouses, Domestic Partners and children of the foregoing)

**Injury**
Bodily Injury that is not intentionally self-inflicted, including all related conditions and recurrent symptoms.

**Inpatient**
Registered as a bed patient in a hospital or extended care facility.

**Medically Necessary**
Medically Necessary care is defined as:

- commonly recognized by the appropriate medical specialist, within standards of good clinical practice,
- appropriate, effective and consistent with the diagnosis or treatment of an illness or Injury,
- the appropriate supply or level of service that can be safely administered,
- provided by a hospital or Covered Provider, and
- a drug or supply approved by the U.S. Food & Drug Administration (FDA).

Medically Necessary care is not:

- Experimental in nature,
- primarily for the convenience of the patient or provider,
- provided primarily for the purpose of medical or other research,
- care that does not require the technical skills of a medical, mental health or dental professional,
- care that is more costly than care that could safely and adequately be furnished in an alternative setting, or
- scholastic, educational or developmental in nature, or intended for vocational training.

**Medicare**
The programs established by Title I of Public Law 89-98 as amended entitled "Health Insurance for the Aged Act."

**Nurse**
A licensed registered nurse (RN) or a licensed practical nurse (LPN), but excluding a member of the Participant’s Immediate Family or a person residing in the Participant’s home.

**Nurse-Midwife**
A licensed registered nurse (RN) who is certified as a Nurse-Midwife by the American College of Nurse-Midwives and is authorized to practice as a Nurse-Midwife under state regulations, but excluding a member of the Participant’s Immediate Family or a person residing in the Participant’s home.

**Outpatient Treatment**
Treatment rendered to a person who is not an Inpatient.

**Participant**
A Subscriber and their Covered Dependents.
Plan
The Healthe Options Component Plan, which includes this document and the Cerner Corporation Wraparound Benefits Plan.

Plan Administrator
Cerner Corporation, unless Cerner Corporation designates another person to hold the position. The Plan Administrator shall be responsible for the administration of the Plan in all respects, including the right to make and enforce rules and regulations it deems necessary, to interpret the Plan, and decide all questions concerning the Plan and its administration. Except as otherwise provided by law, all decisions of the Plan Administrator are final and binding on all parties. In addition to other duties, the Plan Administrator shall have full responsibility for compliance with the reporting and disclosure rules under the Code and ERISA.

Plan Year
A twelve (12) consecutive month period ending every December 31.

PPACA
Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 are collectively referred to as PPACA. PPACA is more commonly known as the Health Care Reform Bill of 2010 or the Affordable Care Act.

Post-Service Claim
Any claim for a benefit under the Plan, other than an Urgent Care Claim or a Pre-Service Claim.

Pharmacy Advocacy Team
The Pharmacy Advocacy team provides confidential medication management services to Covered persons. For Covered persons who has a primary care physician in the Healthe Clinic, the Healthe Pharmacy will provide Pharmacy Advocacy services. For all other Covered persons, Tria Health provides Pharmacy Advocacy services. Tria can be reached at 1-888-799-8742, or by navigating to Pharmacy Advocacy through www.cernerhealth.com.

Pre-Service Claim
Any claim for a benefit under the Plan, if the Plan conditions receipt of such benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Predecessor Employer
Any employer whose employees join Cerner Corporation's controlled group of corporations as part of Cerner Corporation's (or Cerner Corporation's subsidiaries' or affiliates') mergers or acquisitions, provided that such employer is a domestic entity with its principal place of business in the United States.

Semi-Private Room Rate
Means the room and board rate of any institution for semi-private rooms. “Semi-private rooms” are accommodations with two or more beds that are classified by the institution as semi-private. If the institution does not have semi-private rooms, then that institution’s “semi-private room rate” will be deemed to be the most common daily room and board rate for semi-private rooms in similar institutions in the area. The term “area” means a city, county or any greater area necessary to obtain a representative cross-section of similar institutions.

Subscriber
Means the Covered Associate who pays for health insurance premiums under this Plan.
**Transitioned Associate**

Means an Associate who is hired by Cerner as part of Cerner’s agreement to provide certain services to the Associate’s prior employer.

**Urgent Care Claim**

Any claim for medical care or treatment with respect to which medical care decisions, if made on a non-urgent timeframe, (i) could seriously jeopardize the life or health of the Claimant, (ii) could seriously jeopardize the Claimant's ability to regain maximum function, or (iii) in the opinion of a physician knowledgeable of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

**Other Facts You Should Know**

**Right to Discharge**

This Plan is provided as an Associate benefit and does not constitute a contract of employment, give any Associate the right to be retained in the service of Cerner or interfere with the right of Cerner to discharge or otherwise terminate the employment of the Associate.

**Nonpayment of Expenses**

In the unlikely event that neither the Plan nor Cerner pays the medical expenses that are eligible for payment under the Plan, the Participant may be liable for the payment of the expenses.

**Named Fiduciary and Plan Administrator**

Cerner Corporation is the Named Fiduciary and Plan Administrator as defined in ERISA, and, as such, Cerner Corporation has the authority to control and manage the operation and administration of the Plan. Cerner Corporation may delegate such authority to the extent allowable by ERISA.

**Interpretation of Plan**

Cerner Corporation has the exclusive power and authority, in its sole discretion, to construe and interpret the Plan, to determine all questions of Plan coverage and eligibility for benefits, the methods of providing or arranging for such benefits and all other related matters. Any construction of the Plan adopted by Cerner Corporation in good faith and in a consistent and nondiscriminatory manner is binding upon Participants.

**Lawsuits Concerning Benefits**

No lawsuit may be brought by any person or entity to recover benefits under the Plan more than one year from the date Plan benefits are finally denied.

**Workers' Compensation not Affected**

The Plan is not in lieu of, and does not affect any requirement for, coverage under Workers' Compensation.

**Conformity with Law**

If any provision of the Plan is contrary to any law to which it is subject, such provision is automatically amended to conform thereto.
**Failure to Enforce**

Failure to enforce any provision of the Plan shall not affect Cerner's right thereafter to enforce such provision, nor shall such a failure affect its right to enforce any other provision of the Plan.

**Protection against Creditors**

No benefit payment under this Plan is subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind. Any attempt to accomplish the same is void. If Cerner finds that such an attempt has been made, it may, in its sole discretion, elect to pay the benefits due the Participant to the Participant's Spouse, Domestic Partner, parent, adult child, legal guardian of a minor child, sibling or other relative. Any such payment constitutes a complete discharge of Cerner's liability with respect to such benefits.

This provision does not apply to assignments of benefits to the provider of medical care upon which a claim is based.

**Overpayment**

Cerner reserves the right to recover payments made to a Participant or the Participant's assignee in excess of the benefits payable under the Plan. Cerner also reserves the right to withhold the amount of such excess payment from future benefits payable to the Participant or the Participant's assignee.

**Variable Hour Associates**

An Associate is a Variable Hour Associate if, based on the facts and circumstances at his or her hire date, it cannot be determined that the Associate is reasonably expected to work on average at least 30 hours per week and does not otherwise meet the criteria for benefits eligibility.

Effective January 1, 2016, this Plan uses a look-back measurement method to determine if a Variable Hour Associate should be classified as a full-time Associate for purposes of eligibility under this Plan. The look-back measurement method is based on Internal Revenue Service (IRS) final regulations under the Affordable Care Act (ACA).

The look-back measurement method applies to all Variable Hour Associates and involves three different periods:

- **A measurement period** for counting hours of service for Variable Hour Associates:
  - For newly hired Variable Hour Associates, the measurement period will begin on the first day of the month following the Associate's date of hire and will last for 12 consecutive months.
  - For ongoing Variable Hour Associates, this measurement period runs from October 15 through October 14 and will determine an Associate's eligibility for the stability period that follows the measurement period.

- **A stability period** is a period where Variable Hour Associates who worked an average of at least 30 hours per week during the previous measurement period will be deemed full-time employees for purposes of this Plan. As a general rule, status as a full-time Associate or a non-full-time Associate is “locked in” for the stability period, regardless of how many hours worked during the stability period, as long as that Variable Hour Associate remains an Associate and otherwise meets the Plan’s eligibility criteria.
  - For newly hired Variable Hour Associates, the stability period runs for 12 months following the initial measurement period.
  - For ongoing Variable Hour Associates, the stability period runs from January 1 through December 31.
• An administrative period is a short period between the measurement period and the stability period when this Plan performs administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment.
  • For newly hired Variable Hour Associates, the administrative period lasts for 1 calendar month following the end of their measurement period.
  • For ongoing Variable Hour Associates, the administrative period lasts from October 15 through December 31 following each measurement period.

Special rules apply when Associates are rehired by Cerner or return from an unpaid leave. The rules for the look-back measurement method are complex. Keep in mind that this is just a general overview of how the rules work. More complex rules may apply to your situation. Cerner intends to follow the IRS final regulations (including any future guidance issued by the IRS) when administering the look-back measurement method.

Plan Administration/ERISA
This Healthe Options Component Plan is an option under the Cerner Corporation Wraparound Benefits Plan. Cerner is the sponsor of this Plan. Cerner has delegated certain responsibilities of the Plan Administrator to the claims administrator, Cerner HealthPlan Services.

Cerner HealthPlan Services merely processes claims and does not insure the Plan. A Participant’s properly completed claims for Plan benefits will be promptly processed, but in the event there are delays in the processing, a Participant has no greater right to interest or other remedies against Cerner HealthPlan Services than otherwise afforded to the Participant by law.

Employer Address: 2800 Rockcreek Pkwy
North Kansas City, MO 64117

Employer ID Number: 43-1196944
Plan Identification Number: The Plan Identification Number is 501

Participating Employers:
Participating Employer’s include all entities, except for Cerner International, Inc., that (i) are part of Cerner Corporation’s controlled group of corporations, and (ii) are domestic corporations with their principal place of business in the United States.

As of January 1, 2016, the Participating Employers are as follows:

• Cerner Corporation
• Cerner Galt, Inc.
• Cerner Health Connections, Inc. d/b/a Healthe Clinic
• Cerner Health Services, Inc.
• Cerner Healthcare Solutions, Inc.
• Cerner Innovation, Inc.
• Cerner Math, Inc.
• Cerner Multum, Inc.
• Cerner RevWorks, LLC
• Rockcreek Aviation, Inc.
• The Health Exchange, Inc. d/b/a Cerner HealthPlan Services

Type of Administration:
The Plan is administered by the Plan Administrator as a self-funded health plan. Certain functions are performed on behalf of the Plan by Cerner HealthPlan Services. These functions include, but are not limited to, administration and payment of claims, premium billing, customer service assistance, and issuing of Summary Plan Descriptions.

**Plan Administrator:**
Cerner Corporation  
2800 Rockcreek Pkwy  
North Kansas City, MO 64117  
Phone 816-982-7547

**Agent for Service of Legal Process:**
Registered Agent - Delaware  
The Corporation Trust Company  
1209 Orange Street  
Wilmington DE 19801

Registered Agent - Missouri  
CT Corporation System  
120 South Central Avenue  
Clayton MO 63105

Service of process may also be made upon the Plan Administrator.

**Claims Administrator:**
Cerner HealthPlan Services  
P.O. Box 165750  
Kansas City, MO 64116-5750  
Phone 1-877-765-1033

In addition, service of process may be made upon the Administrator or Trustee.

**Plan’s Fiscal Year Ends:**  
12/31

This document, along with the Cerner Corporation Wraparound Benefits Plan & Summary Plan Description, is intended to serve as both the Plan document and the Summary Plan Description (SPD).

This Plan document and SPD has been amended and restated effective January 1, 2016.
Appendix A

Healthe Living with Rewards Program

The Plan offers a comprehensive wellness program (the “Program”), administered by The Health Exchange, Inc. d/b/a Cerner HealthPlan Services, to Eligible Participants (as defined below). The Program offers Eligible Participants a reduction off of the Primary Participant’s Plan premiums and the opportunity to earn additional rewards during the Plan Year. The Program serves two main purposes. First, it provides Eligible Participants with valuable health information while connecting them with a knowledgeable clinical workforce. Second, it helps the Plan determine and prioritize population health management initiatives that best serve the needs of Participants.

Participating in the Program

All Subscribers and their Covered Spouse or Domestic Partner are eligible to participate in the Program (“Eligible Participants”). Participation in the Program is completely optional. Eligible Participants can enroll and earn points through November 30, 2016. A more complete description of the Program and how Eligible Participants can earn points toward premium reduction and HRA contributions (“Points”) can be found at https://healtheatcernerportal.cerner.com.

If an Eligible Participant chooses not to participate they will not be eligible for a reduction in the Plan premium in 2017 or HRA Points in 2016

Associates who are enrolled in the Plan as a Covered Spouse may participate in elements of the Program but will not be eligible for Points, although they may earn Points to be credited under the Subscriber Associate’s HRA.

Newly Hired Associates

Eligible Participants who enroll in the Plan after September 13, 2016 will receive the full premium reduction in 2017, as if they participated in the Program in 2016. The Eligible Participant must complete the required Program components in 2017 to earn a premium reduction in 2018.

Each Participant may earn Points toward their HRA as soon as they enroll in the Program.

Standards of Participation

If it is unreasonably difficult due to a medical condition for an Eligible Participant to achieve the standards for the rewards under this Program, such Eligible Participant should contact the Plan Wellness Program Manager through the HR Service Center and to develop another way to qualify for the Points or for an explanation of the alternative methods available for qualifying for the Points.

Program Components

The Program allows Eligible Participants to opt in to participate in earning Points towards premium reductions for 2017 and HRA dollars to use right away.

All earned premium reduction Points will be reconciled in December 2016 to ensure the correct premium reductions occur for the 2017 plan year.

Earn Premium Reduction Points/Dollars

Subscribers can earn a maximum of 500 Points towards premium reduction, 300 of which must be earned by completing the Wellness Evaluation components (online PHA and Screening (lab and biometrics)).
Increase Health Reimbursement Account

Subscribers without a Covered Spouse or Domestic Partner can earn a maximum of 500 Points to increase their HRA in 2016. If the Subscriber Covers a Spouse or Domestic Partner, the Subscriber can earn up to 700 HRA Points, 200 of which the Spouse or Domestic Partner can earn. If the Spouse or Domestic Partner chooses not to participate, the Subscriber can earn a maximum of 500 Points.

Points earned toward HRA contributions will be available for use in 2016.

For information on the program please log onto https://healthatcernerportal.cerner.com, visit the Healthe at Cerner uCern group (https://connect.ucern.com/community/cerner/associates/groups/health-and-wise), contact AskHR (https://wiki.ucern.com/display/public/HR/HR+Service+Center+Contact+Information) or Consumer Care at (888) 252-8150.

Change of Status
If a Subscriber Covers, as a Dependent, another Participant, who was previously a Subscriber to this Plan (the “New Dependent”), the Plan will recognize any premium reduction Points earned by the Subscriber, and will not recognize any Points earned during the Program year by New Dependent toward the Subscriber’s premium reduction. HRA Points cannot be merged. When a Subscriber terminates coverage under the Plan, all HRA Points earned by all Participants Covered by the Subscriber will be forfeited.

Self-Reporting and Arbitration
Participants should use the self-report options that are available to record activity. Participants will have an opportunity to participate in Point earning activities through November 30, 2016. Participants must report discrepancies in their Point allocations by December 10, 2016 by contacting the HR Service Center, providing all required documentation, and demonstrating his/her completed activity for which he/she would like to receive credit. No Points will be awarded for discrepancies reported after December 10, 2016.

Cost of Program
The Program is a part of the Plan and is available to Eligible Participants. There are no additional Plan deductions from an Eligible Participant’s pay for participation in this Program. However, if an Eligible Participant chooses not to participate in the Program, he or she will not be eligible for premium reduction Points for the following Plan year.

Privacy and Security
The Plan takes Participants’ privacy and security seriously. Please see the Cerner Corporation Wraparound Benefits Plan and Summary Plan Description for information about the privacy and security of Participant’s information.
Appendix B

*Health + Care GPS*

All Participants of the Plan are eligible to enroll and participate in “Health + Care GPS”, services administered by ConsumerMedical. Health + Care GPS is a benefit to help Participant’s obtain current, and personalized information and support regarding their health + care needs. This service provides research, available treatment options, and items to consider for certain medical diagnoses and health topics. To learn more and enroll, please see www.CernerHealth.com.

The program also offers Participants a surgical decision support incentive opportunity. If a Health + Care GPS enrollee has been told by a Doctor that they need to have one of four surgeries: lower back, hip replacement, knee replacement, or hysterectomy, the Health + Care GPS enrollee may be eligible for a $400 gift card. To determine eligibility and learn about the criteria for earning the gift card, please contact ConsumerMedical at 1-888-361-3944.