Association Healthcare Consortium, Inc.
d/b/a KBA Benefits Trust
Health and Welfare Plan

Wrap-Around
Plan Document
and
Summary Plan Description

Amended and Restated January 1, 2020

This document, together with the certificates of insurance, benefit description booklets, and summary plan description issued by KBA Benefits Trust, or an insurance carrier, included herewith, constitutes the Wrap-Around Plan Document and Summary Plan Description for each of the Benefit Programs offered by KBA Benefits Trust with respect to benefits subject to ERISA. If the certificates, booklets, or summaries are not available with this document on the KBA Portal, then this Wrap-Around Plan Document and Summary Plan Description is not complete and you should contact the KBA Benefits Trust for a complete copy.

KBA Benefits Trust has prepared this Wrap-Around Plan Document and Summary Plan Description in good faith to comply with the requirements of the Affordable Care Act (ACA). KBA Benefits Trust reserves the right to amend this Wrap-Around Plan Document and Summary Plan Description, retroactively if deemed necessary, to comply with ACA and the regulations and other guidance promulgated thereunder.

Any party that changes this document, without consultation with a Haynes Benefits PC attorney, agrees to hold Haynes Benefits PC harmless for any liability resulting from the removal or change, including matters involving the accuracy of the document.

LEGAL
COUNSEL
BENEFITING
YOU

HAYNES BENEFITS PC

Association Healthcare Consortium, Inc.
d/b/a KBA Benefits Trust
Health and Welfare Plan

Wrap-Around Plan Document and Summary Plan Description

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Section One
Introduction

1.1 Introduction

The KBA Benefits Trust Health and Welfare Plan (the "Plan" or "Health Plan") is amended and restated effective January 1, 2020. The KBA Benefits Trust maintains the Plan for the exclusive benefit of the Members of KBA Benefits Trust and the Members' Eligible Employees and their eligible Spouses and Dependents, except as provided herein. The Plan has been approved by the Board of Trustees of the KBA Benefits Trust.

Each of these Benefit Programs is summarized in a certificate, booklet or summary issued by an insurance company, a summary plan description, or another governing document prepared by the KBA Benefits Trust. A copy of each certificate, booklet, summary, or other governing document, as noted below as Benefit Documents 1 through 21, are available for your reference through the KBA Portal.

1.2 Purpose of this Wrap Document

The KBA Benefits Trust is providing this Wrap-Around Plan Document and Summary Plan Description ("Wrap Document") to give you an overview of the Plan and to address certain information that may not be addressed in the Benefit Documents. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in the Glossary of this Wrap Document.

1.3 Applicable Law

The Plan is intended to meet the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"), the laws of the state of Kentucky, except to the extent such laws are preempted by ERISA or other federal law, and Section 501(c)(9) of the Internal Revenue Code of 1986 ("Code") and the Regulations promulgated thereunder, as amended from time to time.

1.4 Status as Large Group Plan

KBA Benefits Trust is a multiple employer welfare arrangement. KBA Benefits Trust is designed to be a bona fide association or group of employers under ERISA, and therefore is regulated as a single employer welfare benefit plan on a large group basis.

1.5 Benefit Programs

The Plan provides the following Benefit Programs:

Health/Prescription Program Options: (Fully Insured Programs)

- **Blue Access PPO 1** (Benefit Document 1)
- **Blue Access PPO 2** (Benefit Document 2)
- **Blue Access PPO 3** (Benefit Document 3)
- **Blue Access PPO 4** (Benefit Document 4)
- **Blue Access PPO 5** (Benefit Document 5)
- **Blue Access PPO 6** (Benefit Document 6)
- **Blue Access PPO 7** (Benefit Document 7)
- **Blue Access PPO 8** (Benefit Document 8)
- **Blue Access PPO 9** (Benefit Document 9)
- **Blue Access H.S.A. 1** (Benefit Document 10)
- **Blue Access H.S.A. 2** (Benefit Document 11)
- **Blue Access H.S.A. 3** (Benefit Document 12)
- **Blue Access H.S.A. 4** (Benefit Document 13)
- **Blue Access H.S.A. 5** (Benefit Document 14)
- **Blue Access H.S.A. 6** (Benefit Document 15)
- **Blue Access H.S.A. 7** (Benefit Document 16)

Dental Program Options: (Fully Insured Programs)

- **Delta Dental PPO plus Premier - KBA Option 1** (Benefit Document 17)
- **Delta Dental PPO plus Premier - KBA Option 2** (Benefit Document 18)
- **Delta Dental PPO plus Premier - KBA Option 3** (Benefit Document 19)
- **Delta Dental PPO plus Premier - KBA Option 4** (Benefit Document 20)

Wellness Program: (Self Funded Program)

- **Wellness Program** (Benefit Document 21)

Read Both Documents. You must read this Wrap-Around Plan Document and Summary Plan Description along with the respective Benefit Document for each Benefit Program to understand your Benefits!

You must enroll to receive benefits. Enrollment requirements are explained in Section Three on Eligibility. Some of these Benefit Programs require you to make an annual election to enroll for coverage. The details of such annual election are described in the Benefit Documents.

1.6 Different Types of Documents

This document and the Benefit Documents constitute the Plan Document and Summary Plan Description required by ERISA, for the Benefit Programs to which ERISA applies.

Descriptions of Benefit Programs that are not subject to ERISA may be included in this Wrap Document for purposes of convenience and because there may be other applicable laws (for example, the Internal Revenue Code) that require a written document. Inclusion of Benefit Programs that are not subject to ERISA as part of this Plan is not intended to subject the Benefit Program to ERISA. This Wrap Document is not intended to give you any substantive rights to benefits that are not already provided by the Benefit Documents.

Certain Benefit Programs may not be subject to the requirements of HIPAA. Inclusion of Benefit Programs that are not subject to HIPAA as part of this Plan is not intended to subject the Benefit Programs to HIPAA.

Certain Benefit Programs may be excepted benefits under ERISA, the Internal Revenue Code, the Public Health Service Act (PHSA), and regulations promulgated thereunder. Even though included in this document, Benefit Programs that are excepted benefits are not subject to the portability provisions under HIPAA (e.g. special enrollment rights) or the requirements added under the ACA to the PHSA and incorporated by reference into ERISA and the Code (the "PHSA mandates"). Inclusion of excepted benefits as part of this Plan is not intended to subject the Benefit Programs to the portability provisions under HIPAA or the PHSA mandates.

1.7 More Specific Document Controls

Benefit Programs hereunder are provided pursuant to an insurance contract between the Plan Sponsor and the applicable insurance company, as set forth in the Benefit Document for such Benefit Program. Except for Section Three on eligibility, if the terms of this Wrap Document conflict with or are less specific than the terms of the Benefit Document, then the terms of the Benefit Document will control, rather than the terms of this Wrap Document, unless otherwise required by law. For this purpose, silence in an insurance contract (including the certificate of insurance), plan document, or other governing document is not necessarily a conflict or inconsistency.

Nothing in this document or any of the Benefit Documents shall be construed as to change the funding nature of any Benefit Program from a Fully Insured Benefit Program into a Self Funded Benefit Program. For example, the use of fully insured language and terminology in a Self Funded Document would not change the funding structure of that Benefit.

1.8 Terminology in Benefit Documents

This Wrap Document supplements the terms of the various Benefit Documents. The terminology in the Benefit Documents may have different meanings than the meaning in this Wrap Document. For example, "Member" is defined in the Benefit Documents as enrolled employees and their dependents, while this Wrap Document uses the term "Participant" to refer to enrolled Employees and the term "Member" to refer to participating Employers in the KBA Benefits Trust. A glossary of the terms and their respective meanings is included in each document.

Section Two
General Plan Identifying Information

Name of the Plan	KBA Benefits Trust Health and Welfare Plan
Type of Plan	Employee Welfare Benefits Plan
Address of Plan	600 West Main Street, Suite 400 Louisville, KY 40202 Tel: (844) KBA-PLAN (844) 522-7526
Plan Administrator and Agent for Service of Legal Process	KBA Benefits Trust Attn: Debra K. Stamper, General Counsel 600 West Main Street, Suite 400 Louisville, KY 40202
Named Fiduciary **Board of Trustees**	Board of Trustees of the KBA Benefits Trust Attn: W. Fred Brashear, II, Chair 600 West Main Street, Suite 400 Louisville, KY 40202 Tel: (844) 522-7526 **Chairperson:** W. Fred Brashear **Vice Chairperson:** Neil S. Bryan **Secretary:** Debra K. Stamper **Treasurer:** Ballard W. Cassady, Jr. **Executive Trustee:** Matthew E. Vance
Plan Number	501
Plan Sponsor and its IRS Employer Identification Number	KBA Benefits Trust 600 West Main Street, Suite 400 Louisville, KY 40202 Tel: (844) 522-7526 EIN: 82-1170686
Effective Date	January 1, 2020
Plan Year End	December 31

Health/Prescription Benefit Program – Fully Insured (Benefit Documents 1 - 16)	
Plan Administrator	Board of Trustees of the KBA Benefits Trust Attn: W. Fred Brashear, II, Chair 600 West Main Street, Suite 400 Louisville, KY 40202 Tel: (844) KBA-PLAN (844) 522-7526
Additional Fiduciaries/Insurance Carriers	Anthem Health Plans of Kentucky, Inc. 13550 Triton Park Blvd. Louisville, KY 40223 Tel: (888) 224-4902
Claims Administrators and Appeals Fiduciaries	Anthem Health Plans of Kentucky, Inc. 13550 Triton Park Blvd. Louisville, KY 40223 Tel: (888) 224-4902
COBRA Administrator	KenBanc Insurance KBA Benefits Trust 600 West Main Street, Suite 400 Louisville, KY 40202 Tel: (844) 522-7526
Billing/Enrollment	KenBanc Insurance KBA Benefits Trust 600 West Main Street, Suite 400 Louisville, KY 40202 Tel: (844) 522-7526
Dental Benefit Program – Fully Insured (Benefit Documents 17 - 20)	
Plan Administrator/Fiduciary	Board of Trustees of the KBA Benefits Trust W. Fred Brashear, II, Chair 600 West Main Street, Suite 400 Louisville, KY 40202 Tel: (844) 522-7526
Additional Fiduciary/Insurance Carrier	Delta Dental of Kentucky 10100 Linn Station Road Louisville, KY 40223 Tel: (800) 955-2030

Claims Fiduciary	Delta Dental of Kentucky 10100 Linn Station Road Louisville, KY 40223 Tel: (800) 955-2030
Billing/Enrollment	KenBanc Insurance KBA Benefits Trust 600 West Main Street, Suite 400 Louisville, KY 40202 Tel: (844) 522-7526
Wellness Program – Self Funded (Benefit Document 21)	
Plan Administrator/Fiduciary	Board of Trustees of the KBA Benefits Trust W. Fred Brashear, II, Chair 600 West Main Street, Suite 400 Louisville, KY 40202 Tel: (844) KBA-PLAN (844) 522-7526
Administrator	KBA Benefits Trust 600 West Main Street, Suite 400 Louisville, KY 40202 Tel: (844) 522-7526
Benefit Program Effective Dates	The original effective date of the **Health/Prescription Benefit Program** was January 1, 2017.
	The original effective date of the **Dental Benefit Program** was January 1, 2017.
	The original effective date of the **Wellness Program** was January 1, 2017.
Funding Medium and Type of Plan Administration	Some Benefit Programs under the Plan are Self Funded by the Company and some are Fully Insured under applicable insurance contracts. Insurance premiums for the Fully Insured Benefit Programs are paid in whole or in part by the KBA Benefits Trust out of Trust assets, Member contributions, and in whole or in part by participants' payroll deductions (which may be pre-tax or post-tax).

Funding Medium and Type of Plan Administration *(continued…)*	Contributions for the Self Funded Benefit Program are made by the KBA Benefits Trust out of Trust assets. The Plan Administrators for the various Benefit Programs will provide a schedule of the applicable contributions during the initial and subsequent open enrollment periods and upon request for each of the Benefits Programs, as applicable. The **Health/Prescription Benefit Programs** are Fully Insured by Anthem Health Plans of Kentucky, Inc., which is responsible for paying claims and administering the Health/Prescription Benefit Program. The **Dental Benefit Programs** are Fully Insured by Delta Dental of Kentucky, which is responsible for paying claims and administering the Dental Benefit Programs. The **Wellness Program** is Self Funded by KBA Benefits Trust, which is responsible for paying claims and administering the KBA Benefits Trust Paid Wellness Program.

Section Three
Eligibility and Participation Requirements

Section Three of this Wrap Document provides eligibility and participation requirements and controls over any conflicting or less specific provisions set forth in the various Benefit Documents, except as otherwise required by applicable law.

3.1 Eligibility and Participation

The following individuals are eligible for coverage in the Benefit Programs:

- An Eligible Employee, as defined in the Glossary of this Wrap Document and in the Benefit Document;
- An Eligible Grandfathered Director, as defined in the Glossary of this Wrap Document;
- An Eligible Early Retiree, as defined in the Glossary of this Wrap Document;
- A Spouse, as defined in the Glossary of this Wrap Document and in the Benefit Document; and
- A Dependent/Child, as defined in the Glossary of this Wrap Document and in the Benefit Document.

In order to be a Participant, as provided above, you must:

- Properly enroll in the Plan and properly enroll Dependents in the Plan; and
- Make any required contribution toward the cost of coverage.

In order to be covered as a Dependent, the Employee, Spouse, or Dependent must:

- Properly enroll the individual as a Dependent in the Plan; and
- Make any required contribution toward the cost of coverage.

3.2 Need for Enrollment: Time Limits

Benefit Programs may require the completion of application forms, annual elections, or other administrative forms, as described in the Benefit Documents. If a Benefit Program requires enrollment, new Employees must generally enroll by the first of the month after first becoming eligible, as defined by each employer Member.

Thereafter, enrollment for each Benefit Program is generally limited to the annual enrollment period that occurs before the beginning of each Plan Year, unless circumstances give rise to

special enrollment rights as described below, or unless other enrollment opportunities are available for a particular Benefit Program, as described in the Benefit Documents.

3.3 When Coverage Begins

Coverage for all Benefit Programs begins at the time selected by each Member. For additional information regarding any other issues, such as an "actively-at-work" requirement, contact your Employer or refer to the Benefit Document for the applicable Benefit Program.

3.4 Special Enrollment Rights

In certain circumstances, and with respect to particular Benefit Programs, enrollment may occur outside the open enrollment period, as explained in the Benefit Documents.

If you are an Eligible Employee and you did not enroll yourself, Spouse, or Dependent(s), in the Benefit Programs during the annual enrollment period, you may be able to enroll in the Benefit Programs during a Special Enrollment Period, if a Special Enrollment Event, as defined in the Benefit Document, occurs.

The effective date for coverage under the Benefit Program for an Eligible Employee, Spouse, or Dependent(s) will be the date of the Special Enrollment Event. If a Special Enrollment Event occurs and you wish to enroll during a Special Enrollment Period, you must complete the enrollment process no later than 30 days after the Special Enrollment Event. Acceptable evidence of the Special Enrollment Event may be required in order to continue coverage beyond the first 30 days.

An Eligible Employee, Spouse, or Dependent who loses coverage under the State Children's Health Insurance Program ("SCHIP") or Medicaid may elect to participate in certain coverage under the Benefit Programs. The effective date of coverage will be the date of the loss of coverage under SCHIP or Medicaid, if written application for coverage is made within 60 days of the loss of coverage.

3.5 Required Contribution Payments

A Participant may be required to contribute to pay for coverage under the Health Plan. The KBA Benefits Trust utilizes the insurer's minimum contribution level set for Members. Members determine the required premium contributions by Participants. Members are responsible for notifying Eligible Employees of the required premium contributions, and may change contributions from time to time.

3.6 Termination of Participation

Coverage under a particular Benefit Program will terminate as set forth in the Benefit Document. Depending upon which Benefit Program(s) you are participating in, other circumstances will also result in the termination of your benefits as specified in the Benefit Document. Note that termination of coverage under a particular Benefit Program may not necessarily mean that all

Plan coverage terminates. You (or your covered family member) may still have coverage under another Benefit Program.

Coverage for your Spouse and Dependent(s) stops when your coverage stops and for other reasons specified in the Benefit Document (for example, divorce, Dependent's attaining age limit, and other reasons). Benefits will also cease for you, your Spouse, and Dependent(s) upon termination of the Plan.

Coverage for your Spouse and Dependent(s) will terminate on the earliest of the following dates:

- The date your coverage is terminated or you are no longer an Eligible Employee.
- The first of the month following the date a Spouse or Dependent(s) ceases to be eligible for coverage under the Plan.
- The end of the month following the death of an Eligible Employee, Early Retiree, or Grandfathered Director.
- The date a Spouse or Dependent(s) enters the armed forces of any country or international organization on a full-time active duty basis. This does not apply to scheduled drills or other training not exceeding one month in any calendar year.
- For a newborn or adopted child, the 31st day after the date of birth, adoption or placement for adoption, unless the enrollment procedures are completed on the child before that date.
- The date a Benefit Program is no longer provided under the Plan.

3.7 COBRA Continuation Coverage

If coverage for the Participant, the Participant's eligible Spouse, or eligible Dependents ceases because of certain "qualifying events" (e.g., termination of employment, reduction in hours, divorce, death, or a Child's ceasing to meet the Plan's definition of Dependent) specified in a federal law called COBRA, then the Participant, the Participant's eligible Spouse, or eligible Dependents may have the right to purchase continuing coverage under the Plan for a limited period of time. COBRA Continuation Coverage is available to "Qualified Beneficiaries," who are Covered Persons whose coverage would otherwise be lost because of a "qualifying event," as described below:

- **Participants.** A Participant may elect COBRA Continuation Coverage, (at the Participant's own expense plus a 2% administration fee) if the Participant's participation under the Plan terminates as a result of Termination of Employment or reduction of hours with a Member.

- **Gross Misconduct.** The Plan Administrator will not offer COBRA Continuation Coverage for the Participant or any of the Participant's Dependents where the Plan Administrator determines that the Termination of Employment was due to gross misconduct.

- **Dependents.** A Dependent may elect COBRA Continuation Coverage (at the Dependent's own expense plus a 2% administration fee) if the Dependent's participation under the Plan would terminate as a result of one of the following qualifying events:

    - Death of a Participant;

    - A reduction in hours of a Participant;

    - Termination of Employment of a Participant, except for a termination due to gross misconduct;

    - Divorce or legal separation from a Participant;

    - If the Participant cancels coverage for his or her spouse in anticipation of a divorce or legal separation, and the divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan Administrator within 60 days after the divorce or legal separation and can establish that coverage was cancelled earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation;

    - A Dependent child ceases to qualify as a Dependent under the Plan; or

    - A Participant becomes entitled to Medicare.

Other individuals who may qualify for COBRA Continuation Coverage:

- **Recipients under Qualified Medical Child Support Orders.** A child of the Participant who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order received by the Plan Administrator during the Participant's period of employment with a Member is entitled to the same rights under COBRA as a Dependent child of the Participant, regardless of whether that child would otherwise be considered a Dependent.

- **Children Born to, or Placed for Adoption During COBRA Period.** A child born to, adopted by, or placed for adoption with a Participant during a period of Continuation Coverage is considered to be a Qualified Beneficiary provided that, the Participant has elected Continuation Coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through Special Enrollment or Open Enrollment, and lasts for as long as COBRA coverage for other Qualified Beneficiaries of the Participant. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan requirements.

- **Participants and Dependents after FMLA.** If a Participant takes leave under FMLA and does not return to work at the end of that leave, the Participant and any Dependents will be entitled to elect COBRA if:

    - They were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); or

    - They will lose Plan Coverage within 18 months because of the Participant's failure to return to work at the end of the leave.

      COBRA Continuation Coverage elected in these circumstances will begin on the last day of FMLA leave.

COBRA Continuation Coverage is the same coverage that the Plan gives to other Participants and their Dependents under the Plan that are not receiving COBRA Continuation Coverage, with the exception of the Wellness Program which is not a COBRA eligible Benefit Program. Each Qualified Beneficiary who elects COBRA will have the same rights under the Plan as other Participants or Dependents covered under the Plan, including Open Enrollment and Special Enrollment rights.

- **Duty to Notify Plan Administrator of Qualifying Events.** The Plan Administrator must be timely notified in writing that a qualifying event has occurred in order to be eligible for COBRA Continuation Coverage.

    - Notice must be given by the Employer within **30 days** of the following qualifying events:

        - Termination of Employment of a Participant;

        - Reduction of hours of a Participant;

        - Death of a Participant;

        - Participant becoming entitled to Medicare; or

        - Bankruptcy of Employer.

    - Notice must be given within **60 days** by the Qualified Beneficiary or its representative, for all other qualifying events not previously mentioned, following either:

        - The date of the qualifying event; or

        - The date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

- If the Covered Person provides written notice that does not contain all of the information and documentation required, such notice will nevertheless be considered timely **if all of the following conditions are met**:

  - Notice is mailed or hand delivered by the deadline;

  - The Plan Administrator is able to determine the identity of the Employer, Participant and Qualified Beneficiaries, and the qualifying event from the Notice; and

  - The Notice is supplemented with the requested additional information and documentation to meet the Plan's requirements within 15 business days after a written or oral request from the Plan Administrator.

  If any of the above conditions are not met, the incomplete Notice will be rejected and COBRA will not be offered.

Caution: If these procedures are not followed or if written notice is not provided to the Plan Administrator within the specified time period, any Participant or Dependent who loses coverage will not be offered the option to elect Continuation Coverage.

***Notice Procedures*:** Any notice must be in writing. Oral notice, or notice by telephone, is not accepted. Participant must mail, e-mail or hand-deliver their notice to the agent of the Plan Administrator at this address:

KenBanc Insurance
KBA Benefits Trust
600 West Main Street, Suite 400
Louisville, KY 40202
Tel: (844) 522-7526
eMail: BenefitAdmin@kybanks.com

If mailed, the Participant's notice must be postmarked no later than the last day of the specified time period. Any notice provided must state the name of the Plan *(KBA Benefits Trust)*, the name and address of the Participant covered under the Plan, and the name(s) and address(es) of the Dependent(s) who lost coverage. Participant's notice must also state the qualifying event and the date it happened.

Forms: The Plan's Notice of Qualifying Event Form should be used to notify the agent of the Plan Administrator of a qualifying event. (A copy of this form can be obtained from your Employer or KBA Benefits Trust.) If the qualifying event is a divorce, the notice must include a copy of the divorce decree.

The Plan's Notice of a Second Qualifying Event (a copy of the form can be obtained from your Employer or KBA Benefits Trust) must also state the event and the date it happened. If the qualifying event is a divorce, the notice must include a copy of the divorce decree.

The Participant's Notice of Disability must also include the name of the disabled qualified Dependent, the date when the Dependent became disabled, the date the Social Security Administration made its determination. Participant's Notice of Disability must include a copy of the Social Security Administration's determination, and a statement as to whether or not the Social Security Administration has subsequently determined that the Qualified Beneficiary is no longer disabled (a copy of this form can be obtained from your Employer or KBA Benefits Trust).

- **Electing COBRA Continuation Coverage.** The following rules apply to COBRA election:
  - COBRA Continuation Coverage will begin first of the month following the date of the qualifying event for each Qualified Beneficiary who timely elects COBRA Continuation Coverage;
  - Each Qualified Beneficiary has an independent right to elect Continuation Coverage;
  - A Qualified Beneficiary must elect coverage in writing within 60 days of being provided a COBRA Election Notice, using the Plan's Election Form and following the procedures specified on the Election Form;
  - Written notice of election must be provided to the Plan Administrator at the address provided on the Plan's Election Form. If mailed, the election must be postmarked no later than the 60th day of the election time period;
  - A Participant or Dependent may change a prior rejection of Continuation Coverage at any time during the specified time period by providing the Notice of Election;
  - A Participant or Dependent who fails to elect Continuation Coverage within the specified time period will lose his or her right to elect Continuation Coverage; and
  - Unless otherwise indicated, an affirmative election of COBRA Continuation Coverage by a Participant shall be deemed to be an election for that Participant's Dependents who would otherwise lose coverage under the Plan.

    The Participant (i.e. the Employee or former Employee who is or was covered under the Plan), a Qualified Beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the Notice of Election on behalf of all Qualified Beneficiaries who lost coverage due to the qualifying event described in the Notice.

Note Regarding Failure to Elect. In considering whether to elect Continuation Coverage, Participant should take into account that a failure to continue their group health coverage will affect Participant's future rights under federal law.

The Participant should take into account that they have Special Enrollment rights under federal law. The Participant has the right to request Special Enrollment in another group health plan for which the Participant is otherwise eligible (such as a plan sponsored by the Participants spouse's employer) within 30 days after the Participant's group health coverage ends. The Participant will also have the same Special Enrollment right's at the end of Continuation Coverage if the Participant gets Continuation Coverage for the maximum time available to Participant.

- **Length of Continuation Coverage.** COBRA Continuation Coverage is a temporary continuation of coverage. The COBRA Continuation Coverage periods described below are maximum coverage periods.

- **Period of Continuation Coverage for Participants.** A Participant, who qualifies for COBRA Continuation Coverage as a result of Termination of Employment or reduction in hours of employment, may elect COBRA Continuation Coverage for up to 18 months measured from the date of the qualifying event.

  Coverage under this Section may not continue beyond:

  - The date on which the Member ceases to maintain a group health plan;
  - The last day of the month for which the required contributions have been made;
  - The date the Participant becomes entitled to Medicare; or
  - The first day after the COBRA Continuation Coverage election, when the Participant is covered under any other group health plan that is not maintained by VPC Benefits Consortium, provided the new group plan does not have a preexisting condition limitation that affects the Participant.
  - COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate coverage of a Covered Person not receiving COBRA Continuation Coverage (*i.e.* filing fraudulent claims).

- **Period of COBRA Continuation Coverage for Dependents.** If a Dependent elects COBRA Continuation Coverage under the Plan as a result of the Participant's Termination of Employment or reduction in hours of employment as described above, Continuation Coverage may be continued for up to 18 months measured from the date of the qualifying event. COBRA Continuation Coverage for all other qualifying events may continue for up to 36 months.

In addition to maximum periods discussed immediately above, Continuation Coverage under this subsection may not continue beyond:

- The last day of the month for which required contributions have been made;
- The date the Dependent becomes entitled to Medicare;
- The date which the Member ceases to maintain a group health plan; or
- The first day after the COBRA Continuation Coverage election, when the Participant is covered under any other group health plan that is not maintained by the VPC Benefits Consortium provided that the new group plan does not have a preexisting condition limitation that affects the Dependent.

  COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or Dependent not receiving COBRA Continuation Coverage (*i.e.* such as fraud).

- **Contribution Requirements for COBRA Continuation Coverage.** Participants and Dependents who elect COBRA Continuation Coverage as a result of one of the qualifying events specified must make Continuation Coverage Payments.

  Participants and Dependents must make the Continuation Coverage Payments monthly prior to the first day of the month in which such coverage will take effect. However, a Participant or Dependent has 45-days from the date of an affirmative election to pay the Continuation Coverage Payment for the period between the date medical coverage would otherwise have terminated due to the qualifying event and the date the Participant and/or Dependent actually elects COBRA Continuation Coverage, and for the first month's coverage. The Participant and/or Dependent shall have a **31-day** grace period to make the Continuation Coverage Payments due thereafter. Continuation Coverage Payments must be postmarked on or before the completion of the **31-day** grace period. If Continuation Coverage Payments are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day of the month for which required contributions were made. The **31-day** grace period shall not apply to the **45-day** period for payment of COBRA premiums as set out in this Subsection.

- **Cost of COBRA Continuation Coverage.**
  - **Amount**. Each Qualified Beneficiary may be required to pay the entire cost of Continuation Coverage. The amount a Qualified Beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both Employer and Participant contributions) for coverage of a similarly situated Plan Participant who is not receiving Continuation Coverage, (or in the case of an extension of Continuation Coverage due to a Disability, 150%).

- **Timely Payment of Premiums**. Participants and Dependents who elect COBRA Continuation Coverage as a result of one of the Qualifying Events specified above must make Continuation Coverage Payments within the timeframes as referenced above under Contribution Requirements, to be considered timely.

- **Limitation on Participant's Rights to COBRA Continuation Coverage.**

  - If a Dependent loses, or will lose medical coverage, under the Plan as a result of a divorce or ceasing to be a Dependent, the Participant or Dependent is responsible for notifying the Plan Administrator within **60 days** of the divorce or loss of Dependent status. Failure to make timely notification will terminate the Dependent's rights to COBRA Continuation Coverage under this Section.

  - A Participant or Dependent must complete, sign and return the required enrollment materials within **60 days** from the later of:

    - Loss of coverage; or

    - The date the Plan Administrator or authorized representative of the Plan sends notice of eligibility for COBRA Continuation Coverage.

    - Failure to enroll for COBRA Continuation Coverage during this 60-day period will terminate all rights to COBRA Continuation Coverage under this Plan. An affirmative election of COBRA Continuation Coverage by a Participant or Participant's spouse shall be deemed to be an election for that Participant's Dependents who would otherwise lose coverage under the Plan.

- **Second Qualifying Event.** If a second qualifying event which would entitle a Spouse or Dependent(s) to 36 months of Continuation Coverage occurs during an 18-month extension explained above, coverage may be continued for a maximum of 36 months from the date of the first qualifying event provided that the Qualified Beneficiary notifies the Plan Administrator within **60 days** of the second qualifying event. Such second qualifying events include the death of a Participant, divorce from a Participant, or a Dependent child ceasing to be eligible for coverage as a Dependent under the Plan. Participant must notify the Plan Administrator within **60 days** after the second qualifying event using the Notice Procedures previously stated. (Generally, this second qualifying event extension is not available under the Plan when a Participant becomes entitled to Medicare during the initial 18-month period of Continuation Coverage). **Failure to provide timely notice will result in non-extension of COBRA Continuation Coverage.**

- **Medicare or Other Group Health Coverage.**

  Note: Participant must notify the agent of the Plan Administrator if any Qualified Beneficiary has become entitled to Medicare and the date of Medicare entitlement.

Qualified Beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA Continuation Coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under another group health plan (but only after any applicable preexisting condition exclusions of the other plan have been exhausted or satisfied).

- **Extension of COBRA Continuation Period for Disabled Participants.** The period of continuation shall be extended to 29 months (measured from the date of the qualifying event) in the event:

    - The Participant is disabled (as determined by the Social Security laws) within **60 days** after the date of the qualifying event; and

    - The individual provides evidence to the Plan Administrator or authorized representative of such Social Security Administration determination prior to the earlier of 60 days after the date of the Social Security Administration determination, or the expiration of the initial 18 months of COBRA Continuation Coverage.

    - In such event, the Plan may charge the individual up to 150% of the amount of the group health plan cost for the COBRA coverage for all months after the 18th month of COBRA coverage, as long as the disabled Participant is in the covered group. The Participant must notify the Plan Administrator if a Participant is deemed no longer disabled, in which case COBRA Continuation Coverage ends as of the first day of the month that is more than **30 days** after the Social Security Administration determination.

3.8 USERRA Continuation Coverage

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the Uniformed Services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage available pursuant to USERRA is included in the Benefit Documents.

You May Have Rights Under COBRA and USERRA. For Benefit Programs to which COBRA and USERRA apply, your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA. COBRA and USERRA may both apply with respect to the continuation coverage elected. If COBRA or USERRA give you or your covered Dependents different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures for COBRA also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstance.

3.9 Qualified Medical Child Support Orders

The Plan will extend medical benefits to an Eligible Employee's non-custodial Child as required by any Qualified Medical Child Support Order (QMCSO) under ERISA §609(a), including a National Medical Support Notice. Members have procedures for determining whether an order qualifies as a QMCSO. You can obtain, without charge, a copy of such procedures from your employer Member.

3.10 Family and Medical Leave

If a Participant is on a Family or Medical Leave of Absence, the Participant may continue coverage in accordance with the Family and Medical Leave Act, and the Plan will continue coverage, as if the Participant was Actively at Work if the following conditions are met:

- The required Contribution is paid; and
- The Participant has written approval of leave from the Employer Member.

Coverage will be continued for up to the greater of:

- The leave period required by the Family and Medical Leave Act of 1993 and any amendments thereto or regulations promulgated thereunder; or
- The leave period required by applicable state law.

If coverage is not continued during a Family or Medical Leave of Absence, when the Participant returns to Actively at Work status no new Waiting Period will apply.

Section Four
Plan Benefits Summary

4.1 Benefits

The Plan provides you and your eligible dependents with benefits under the Benefit Programs as set forth in Section One of this Wrap-Around Plan Document. A summary of each Benefit Program, describing the benefits provided under the program is set forth in the Benefit Documents.

4.2 Premiums and Contributions

The cost of the benefits provided through the Health Plan will be funded in part by Member contributions and in part by Participant contributions (which may be pre-tax or after-tax). The Member will determine and periodically communicate the Participant's share of the cost of the benefits provided through the Health Plan, which may change at any time.

4.3 Rebates, Refunds, and Similar Payments

Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be allocated consistent with applicable fiduciary obligations under ERISA.

The following three notices in Sections 4.4 through 4.6 apply to the Health/Prescription and Dental Benefit Programs *(but only to the extent they provide applicable benefits).*

4.4 Newborns and Mothers Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother of the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending physician (e.g., your physician, nurse or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits for out of pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

4.5 Reconstructive Surgery Following Mastectomy

The Women's Health and Cancer Rights Act of 1998 requires group health plans to provide coverage for breast reconstruction, prostheses and complications following a mastectomy. The law mandates that a Participant or Dependent who is receiving benefits for a mastectomy and

who elects breast reconstruction in connection with the mastectomy, will also receive coverage for:

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

This coverage will be provided in a manner determined in consultation with the attending Physician and the patient, and will be subject to the same annual Deductible, Coinsurance and/or Copayment provisions otherwise applicable under the Plan. If you have any questions about coverages for mastectomies and post-operative reconstructive surgery, please contact the applicable Plan Administrator.

4.6 Michelle's Law

A Dependent will not lose status as a Dependent while on a Medically Necessary Leave of Absence. A "Medically Necessary Leave of Absence" is a leave of absence from a post-secondary educational institution that:

- Commences while the Dependent is suffering from a severe illness or injury;
- Is medically necessary (as certified by the Dependent's physician);
- Causes the dependent to lose full time student status under the Plan.

Coverage may not terminate due to the Medically Necessary Leave of Absence until the earlier of:

- One year after the first day of the Medically Necessary Leave of Absence; or
- The date the coverage would otherwise terminate under the Plan.

(Section 4.6 may not be applicable due to ACA's age 26 dependent coverage mandate).

Section Five
Plan Administration

5.1 Plan Administrators

The Plan Administrators for the various Benefit Programs of the Plan are identified above in Section Two.

5.2 Power of Plan Administrators

Subject to the limitations of the Plan and any Benefit Document, the Plan Administrators will from time to time establish rules for the administration of the various Benefit Programs of the Plan and transaction of its business. The Plan Administrators will rely on the records of the Member with respect to any and all factual matters dealing with the employment and eligibility of an employee. The Plan Administrators will resolve any factual dispute, giving due weight to all evidence available to it. The Plan Administrators shall have such powers and duties as may be necessary to discharge its functions hereunder, including but not limited to, the sole and absolute discretion to:

- Construe and interpret the various Benefit Programs of the Plan;
- Decide questions of eligibility to participate in the various Benefit Programs of the Plan; and
- Determine the amount, manner and time of payment of any benefit to any covered person.

The Plan Administrators will have final discretionary authority to make such decisions and all such determinations shall be final, conclusive and legally binding.

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

5.3 Outside Assistance

The Plan Administrators may employ such counsel, accountants, claims administrators, consultants, actuaries and other person or persons as the Plan Administrators shall deem advisable. The various Benefit Programs of the Plan shall pay the compensation of such counsel,

accountants, and other person or persons and any other reasonable expenses incurred by the Plan Administrators in the administration of the various Benefit Programs of the Plan.

5.4 Delegation of Powers

In accordance with the provisions hereof, the Plan Administrators have been delegated certain administrative functions relating to the various Benefit Programs of the Plan with all powers necessary to enable the Plan Administrators properly to carry out such duties. The Plan Administrators as such shall have no power in any way to modify, alter, add to, or subtract from any provisions of the various Benefit Programs of the Plan other than expressly provided in this Wrap-Around Plan Document and SPD or the Benefit Documents.

The Plan Administrator may delegate any of these administrative functions among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibility.

5.5 Power and Authority of Insurance Companies

The following list of benefits programs are Fully Insured and provided under group insurance contracts entered into by the KBA Benefits Trust and the applicable insurance companies:

Benefit Program	Insurance Company
Health/Prescription Benefit Program	Anthem Health Plans of Kentucky, Inc.
Dental Benefit Program	Delta Dental of Kentucky

You should send claims for benefits under these Benefit Programs to the insurance companies. The insurance companies are responsible for (a) determining eligibility for and the amount of any benefits under the applicable Benefit Program; (b) prescribing claims procedures to be followed and the claim forms you should use pursuant to the applicable Benefit Program; and (c) payment of all benefits under the applicable Benefit Program. The KBA Benefits Trust does not assume any responsibility for paying claims under these Benefit Programs. However, the insurance companies and the KBA Benefits Trust share responsibility for administering the Plan.

5.6 Your Questions

If you have any general questions regarding the Plan or regarding your eligibility for the Plan, please contact KBA Benefits Trust at (844) 522-7526.

If you have questions regarding eligibility for, or the amount of, any benefits payable under a Fully Insured Benefit Program, please contact the applicable insurance company as provided in the Benefit Document.

Section Six
Circumstances That May Affect Benefits

6.1 Denial, Recovery or Loss of Benefits

Your benefits (and, except in some cases in the event of your death, the benefits of your eligible spouse and eligible dependents) will cease when your participation in the Plan terminates. See Section Three. Your benefits will also cease upon termination of the Plan. Your benefits under any individual Benefit Program will cease upon termination of any such individual Benefit Program.

6.2 Rescission of Coverage

The Plan Administrator reserves the right to rescind coverage under the Plan if an employee, spouse or child becomes covered under this Plan or receives Plan benefits as a result of an act, practice or omission that constitute fraud or is due to the intentional misrepresentation of a material fact, both of which are prohibited by this Plan. Rescission is a cancellation and discontinuance of coverage, retroactive to the date the employee, spouse or child became covered or received a Plan benefit as a result of fraud or the intentional misrepresentation of a material fact. The Plan Administrator will provide at least 30 days advance notice to an employee, spouse or child of its intent to rescind coverage with an explanation of the reason for the intended rescission. The rescission shall not apply to benefits paid more than one year before the date of such advance notice. A cancellation or discontinuance of coverage is not a rescission if:

- The cancellation or discontinuance of coverage only has a prospective effect; or
- The cancellation or discontinuance of coverage is only retroactive to the extent it is attributable to the timely failure to pay Premiums (including COBRA Premiums) toward the cost of coverage. A rescission is subject to the claims payment and appeal procedures described in Article 9.

6.3 Reimbursement and Subrogation

In certain circumstances, the Plan may recover overpaid benefits through its rights to subrogation and reimbursement. These Plan rights are described in detail in the Benefit Documents.

Section Seven
Amendment or Termination of the Plan

7.1 Right to Amend, Merge or Consolidate

The KBA Benefits Trust reserves the right to merge or consolidate the Plan or any individual Benefit Program, and to make any amendment or restatement to the Plan or any individual Benefit Program from time to time, including those which are retroactive in effect. Such amendments may be applicable to any covered person. Terminating a Benefit Program (including terminating an insurance contract through which such benefits are provided) is not a termination of the Plan. Rather, it is an amendment to the Plan.

Any amendment or restatement shall be deemed to be duly executed by KBA Benefits Trust when signed by an individual authorized by the Board of Trustees of the KBA Benefits Trust.

7.2 Right to Terminate

The Plan and its individual Benefit Programs are intended to be permanent, but the KBA Benefits Trust may at any time and without notice terminate the Plan or any individual Benefit Program in whole or in part.

7.3 Effect on Benefits

Except as may otherwise be provided by applicable law or the Benefit Documents, if the Plan or any individual Benefit Program is amended or terminated, covered persons may not receive benefits described in the Plan or in any individual Benefit Program after the effective date of such amendment or termination. Any such amendment or termination shall not affect a covered person's right to benefits for claims incurred prior to such amendment or termination. If the Plan or any individual Benefit Program is amended, covered persons may be entitled to receive different benefits or benefits under different conditions. However, if the Plan is terminated, all benefit coverage will end, including COBRA or other continuation benefits. This may happen at any time. If the Plan is terminated, covered persons will not be entitled to any vested rights under the Plan.

Section Eight
No Contract of Employment

Nothing contained in the Plan or the Benefit Programs shall be construed as a contract of employment with the Company, or as a right to be continued in the employment of the Company, or as a limitation of the right of the Company to discharge any of the participants, with or without cause.

Section Nine
Claims and Appeals Procedures

9.1 Claims and Appeals for Fully Insured Benefit Programs

For purposes of determining the amount of, and entitlement to, benefits of the Fully Insured Benefit Programs, the respective insurer is the Claims Fiduciary (as specified in Section Two) under the Plan. The Claims Fiduciary has the full power to interpret and apply the terms of the Plan to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a Benefit Program, you must follow the respective insurer's claims procedures. (See the Benefit Documents for more information).

The insurance company will decide your claim in accordance with its reasonable claims procedures, as required by any applicable provisions of ERISA (if ERISA applies) and ACA. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide a claim. If the insurance company denies a claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, you may appeal to the insurance company for a review of the denied claim. The insurance company will decide the appeal in accordance with its reasonable claims procedures, as required by any applicable provisions of ERISA (if ERISA applies) and ACA. If you do not appeal on time, then you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). To the extent the Benefit Program is subject to provisions of ACA requiring external review, procedures to that effect will be available.

The applicable insurance contract (including the certificate, booklet or summary) provides more information about how to file a claim and details regarding the insurance company's claims procedures.

9.2 Claims Deadline

Unless specifically provided otherwise in a Benefit Program or pursuant to applicable law, a claim for benefits under this Plan (including the Benefit Programs) must be made within 12 months after the date of service, except in the absence of legal capacity. It is your responsibility, or the responsibility of your designee to make sure this requirement is met.

9.3 Administrative Exhaustion Requirement

All claim review procedures provided for in the Plan must be exhausted before any legal action is brought including a claim for benefits or for breach of fiduciary duty.

9.4 Limitation on Actions

To the extent not otherwise specified in the applicable Benefit Document, any legal action for the recovery of any benefits or breach of fiduciary duty must be commenced within one year after the Plan's claim review procedures have been exhausted.

9.5 Failure to File a Request

If you fail to file a request for review in accordance with the claims procedures outlined herein and in the Benefit Documents, you shall have no right of review and shall have no right to bring action in any court. The denial of the claim shall become final and binding on all persons for all purposes.

Section Ten
Statement of ERISA Rights

Note: This Statement of ERISA Rights does not apply to the Wellness Program or to any other Benefit Programs to which ERISA does not apply.

10.1 Your Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to the following rights:

10.2 Receive Information About Your Plan and Benefits

You may examine without charge at KBA Benefits Trust's principal office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You may obtain, upon written request to Human Resources, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

You may receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the KBA Benefits Trust, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

10.3 COBRA and HIPAA

You may continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You, your spouse, or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

10.4 Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

10.5 Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Company, as Plan Administrator to provide the materials and pay you up to $ 110 per day until you receive the materials unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits, which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees, if you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

10.6 Evidence in Litigation

If you file suit in a state or federal court, you can only present evidence which was previously submitted during the claims or appeals process. You cannot present new evidence in court.

10.7 Assistance with Your Questions

If you have any questions about your Plan, you should contact KBA Benefits Trust. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrators of the various Benefit Programs, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section Eleven
Plan Information

11.1 Fully Insured Benefit Programs Contracts Control

Benefits under the Fully Insured Benefit Programs are provided solely pursuant to insurance contracts between the Plan Sponsor and the applicable insurance companies, as set forth in the Benefit Document for such Benefit Program. If the terms of this Wrap-Around Plan Document conflict with the terms of the Benefit Document, the terms of the Benefit Document will control, unless superseded by applicable law. For this purpose, silence in an insurance contract (including the certificate of insurance) plan document, or other governing document is not necessarily a conflict or inconsistency.

11.2 Self Funded Benefit Program Plan Documents Control

Benefits under the Self Funded Benefit Program are provided solely pursuant to the Plan Document, SPD, or other governing document. If the terms of this Wrap-Around Plan Document and SPD conflict with the terms of the Plan Document, SPD or other governing document of any Self Funded Benefit Program, the terms of the Plan Document, SPD or other governing document will control, unless superseded by applicable law. For this purpose, silence in a Plan Document, SPD, or other governing document is not necessarily a conflict or inconsistency.

11.3 Compliance with Federal Mandates

To the extent applicable, the Plan will provide benefits in accordance with the requirements of all applicable laws and as described in the certificate, booklet or summary, including the following:

- Employee Retirement Income Security Act of 1974 (ERISA);
- Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA);
- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA);
- Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- Newborns' and Mothers' Health Protection Act of 1996 (NMHPA);
- Women's Health and Cancer Rights Act of 1998 (WHCRA);
- Genetic Information Nondiscrimination Act of 2008 (GINA):
- The Health Information Technology for Economic and Clinical Health Act (HITECH);
- Mental Health Parity and Addiction Equity Act (MHPAEA); and
- The Affordable Care Act (ACA).

11.4 Verification

The Plan Administrators for the various Benefit Programs shall be entitled to require reasonable information to verify any claim or the status of any person as an eligible employee or dependent. If the employee or dependent does not supply the requested information within the applicable time limits or provide a release for such information, such employee or dependent shall not be entitled to benefits under the Plan.

11.5 Limitation of Rights

Nothing appearing in or done pursuant to the Plan shall be held or construed:

- To give any person any legal or equitable right against the Company, any of its employees, or persons connected therewith, except as provided by law; or

- To give any person any legal or equitable right to any assets of the Plan or any related trust, except as expressly provide herein or as provided by law.

11.6 Governing Law

The Plan is intended to be construed, and all rights and duties hereunder are to be governed, in accordance with the laws of the State of Kentucky, except to the extent such laws are preempted by ERISA or other federal law.

11.7 Severability

If any provision of the Plan is held invalid or unenforceable, its validity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

11.8 Caption

The captions contained herein are inserted only as a matter of convenience and for reference and in no way define, limit, enlarge or describe the scope or intent of the Plan nor in any way shall affect the Plan or the construction of any provision thereof.

11.9 Federal Tax Disclaimer

To ensure compliance with requirements imposed by the Internal Revenue Service, we inform you that to the extent this communication (including any of the Benefit Documents) contains advice relating to a Federal tax issue, it is not intended or written to be used, and it may not be used, for the purpose of (a) avoiding any penalties that may be imposed on you or any other person or entity under the Internal Revenue Code or (b) promoting, marketing or recommending to another party any transaction or matter addressed herein. If you are not the original addressee of this communication, you should seek advice from an independent advisor based on your particular circumstances.

Glossary

Capitalized terms used in the Plan have the following meanings:

Code means the Internal Revenue Code of 1986, as amended.

Company means Association Healthcare Consortium, Inc. d/b/a KBA Benefits Trust, and any wholly owned subsidiary specifically identified in Section 1, and any successor thereto.

Benefit means the specific benefit(s) contained within a certificate, booklet, summary or other governing document in which an Eligible Employee participates.

Benefit Program means the program under which the specific Benefit(s) are held.

Benefit Program Effective Date means the individual dates listed in Section 2.

Benefit Document means the certificate, booklet or summary issued by an insurance company, a summary plan description, or another governing document prepared by the Company summarizing the Benefit Programs.

Dependent means an individual who is an Eligible Employee's or Eligible Employee's Spouse's child, including natural children, stepchildren, newborn and legally adopted children, children who the Member has determined are covered under a "Qualified Medical Child Support Order" (as defined by ERISA or any applicable state law), and children for who the Eligible Employee or Eligible Employee's Spouse is a legal guardian.

All enrolled eligible children will continue to be covered until the age limit listed in the Benefit Document.

Eligibility will be continued past the age limit only for Dependents already enrolled, and who cannot work to support themselves due to mental retardation or physical or mental handicap.

These Dependents must be allowed as a federal tax exemption by the Eligible Employee or Eligible Employee's Spouse. The Dependent's disability must start before the end of the period they would become ineligible for coverage. The Plan must certify the Dependent's eligibility. The Plan must be informed of the Dependent's eligibility for continuation of coverage within 31 days after the Dependent would normally become ineligible.

The Eligible Employee must submit proof of continued eligibility for any enrolled child, periodically. Failure to provide this information could result in termination of a child's coverage.

Eligible Employee means a common-law employee of a Member who satisfies the eligibility provisions of Section 3, works at least 30-hours per week (or a lower number of hours, as low as 20-hours per week, if elected the employer Member), and satisfies the eligibility provisions of the applicable Benefit Program.

Eligible Grandfathered Directors means if elected by the employer Member, an individual who served continuously on a Member's board of directors since prior to January 1, 2011, and thereafter any director who has not yet turned age 65 and is eligible for other benefits offered by the Company.

Eligible Early Retiree means if elected by the employer Member, an individual is retired and satisfies the following eligibility requirements: is age 60-65; was employed by a Member prior to retirement; was covered by a Benefit Program under the Plan prior to retirement and continuously thereafter; is not eligible for group health insurance elsewhere as an employee; and meets any other eligibility rules required by the employer Member or described in the applicable Benefit Document.

Member means an employer who meets the requirements of an Active Member of the Kentucky Bankers Association ("KBA"), as defined in the Bylaws of the KBA, who is approved for participation in the Plan by a majority of the Board of Trustees, and has executed an adoption agreement to participate in Benefit Programs under the Plan.

Participant means a person who is an Eligible Employee, Eligible Early Retiree, and Eligible Grandfathered Director, and who is participating in this Plan in accordance with the provisions of Section 3.

Plan means this KBA Benefits Trust Health and Welfare Plan.

Plan Administrator means, with respect to the KBA Benefits Trust Health and Welfare Plan, the Board of Trustees of the KBA Benefits Trust. With respect to Benefit Programs, Plan Administrator means the entity identified as the Plan Administrator in Section 2.

Plan Effective Date means January 1, 2020.

Spouse means an individual who meets the following eligibility requirements: is legally married to a Eligible Employee, (including a common law marriage, if the common law marriage was formed in a state that recognizes the legally valid formation of a common law marriage), the marriage of the individual and the Eligible Employee is recognized on the relevant date as legally valid in the state where the Eligible Employee resides, and; the Spouse is not eligible to enroll in health insurance through his or her employer.

If requested by the Plan Administrator, a common-law spouse must demonstrate that his or her common-law marriage is valid and legally recognized in the state of formation.

Special Enrollment Event means a change as defined in the Benefit Documents.

IN WITNESS WHEREOF, KBA Benefits Trust has caused this Wrap-Around Plan Document and Summary Plan Description to be executed, effective January 1, 2020.

Association Healthcare Consortium, Inc.
d/b/a KBA Benefits Trust

By:_____

Its:_____

Attest:

By:_____

Its:_____

Benefit Program Documents

The Plan provides the following Benefit Programs:

Health/Prescription Program Options: (Fully Insured Programs)

- **Blue Access PPO 1** (Benefit Document 1)
- **Blue Access PPO 2** (Benefit Document 2)
- **Blue Access PPO 3** (Benefit Document 3)
- **Blue Access PPO 4** (Benefit Document 4)
- **Blue Access PPO 5** (Benefit Document 5)
- **Blue Access PPO 6** (Benefit Document 6)
- **Blue Access PPO 7** (Benefit Document 7)
- **Blue Access PPO 8** (Benefit Document 8)
- **Blue Access PPO 9** (Benefit Document 9)
- **Blue Access H.S.A. 1** (Benefit Document 10)
- **Blue Access H.S.A. 2** (Benefit Document 11)
- **Blue Access H.S.A. 3** (Benefit Document 12)
- **Blue Access H.S.A. 4** (Benefit Document 13)
- **Blue Access H.S.A. 5** (Benefit Document 14)
- **Blue Access H.S.A. 6** (Benefit Document 15)
- **Blue Access H.S.A. 7** (Benefit Document 16)

Dental Program Options: (Fully Insured Programs)

- **Delta Dental PPO plus Premier - KBA Option 1** (Benefit Document 17)
- **Delta Dental PPO plus Premier - KBA Option 2** (Benefit Document 18)
- **Delta Dental PPO plus Premier - KBA Option 3** (Benefit Document 19)
- **Delta Dental PPO plus Premier - KBA Option 4** (Benefit Document 20)

Wellness Program: (Self Funded Program)

- **Wellness Program** (Benefit Document 21)