BLACKWATER COMMUNITY SCHOOL

EMPLOYEE BENEFIT PLAN

EPO PLAN OPTION

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

EFFECTIVE DATE: OCTOBER 1, 2015

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ADOPTION

Blackwater Community School has caused this Blackwater Community School Employee Benefit Plan EPO Plan Option ***(Plan)*** to take effect as of the first day of October 2015, at Coolidge, Arizona. I have read the document herein and certify the document reflects the terms and conditions of the employee welfare benefit plan as established by Blackwater Community School.

PLAN ADMINISTRATOR: BLACKWATER COMMUNITY SCHOOL

BY:_____ DATE:_____

SUMMARY PLAN DESCRIPTION

Name of Plan:

Blackwater Community School Employee Benefit Plan EPO Plan Option

Name, Address and Phone Number of Employer/Plan Sponsor:

Blackwater Community School
3652 E. Blackwater School Road
Coolidge, Arizona 85128
Phone: (520) 215-7910

Employer Identification Number:

74-2422892

Plan Number:

501

Type of Plan:

Group Health Plan providing coverage for: medical and prescription drug benefits

Type of Administration:

Contract administration: The processing of claims for benefits under the terms of the ***Plan,*** is provided through a company contracted by the ***employer*** and shall hereinafter be referred to as the ***claims processor.***

Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent for Service of Legal Process:

Blackwater Community School
3652 E. Blackwater School Road
Coolidge, Arizona 85128
Phone: (520) 215-7910

Eligibility Requirements:

For detailed information regarding a person's eligibility to participate in the ***Plan,*** refer to the following sections:

Eligibility
Enrollment
Effective Date of Coverage

Schedule of Benefits:

Eligible, enrolled ***employees*** and ***dependents*** are covered for the benefits under this ***Plan.*** Refer to the section entitled, *Schedule of Benefits.* The *Schedule of Benefits* will list all applicable ***maximum benefits;*** the extent to which preventive services are covered under the ***Plan;*** whether, and under what circumstances, existing and new drugs are covered under the ***Plan;*** whether, and under what circumstances, coverage is provided for medical tests, devices and procedures.

Procedures for Qualified Medical Child Support Orders:

Employees and ***dependents*** may obtain, without charge, a copy of the ***employer's*** procedures governing Qualified Medical Child Support Orders (QMCSO).

Employee/Dependent Contributions:

The amount of contributions paid for by the ***employer*** on behalf of the ***employee*** and the ***employee's dependents*** is determined by the ***employer.*** An ***employee*** may contact the ***employer*** for a current listing of the contribution schedule.

Employee/Dependent Cost Sharing:

All ***covered expenses*** are subject to applicable ***Plan*** provisions including, but not limited to: deductible, ***copay, coinsurance*** and ***maximum benefit*** provisions as shown in the *Schedule of Benefits*, unless otherwise indicated. Any expenses ***incurred*** by the ***covered person*** for services, supplies or treatment provided will not be considered ***covered expenses*** by this ***Plan*** if they are greater than the ***customary and reasonable amount*** for ***nonpreferred providers.***

Provider Network:

The ***Plan*** uses a ***Preferred Provider Organization***. A ***preferred provider*** is a ***physician, hospital*** or ancillary service provider which has an agreement in effect with the ***Preferred Provider Organization*** (PPO) to accept a reduced rate for services rendered to ***covered persons.*** This is known as the ***negotiated rate.*** The ***preferred provider*** cannot bill the ***covered person*** for any amount in excess of the ***negotiated rate. Covered persons*** should contact the Human Resources Department for a current listing of ***preferred providers.*** This PPO listing is provided at no charge. No ***preferred provider*** benefits are available outside Arizona.

The sections entitled, *Schedule of Benefits* and *Preferred Provider* will address provisions governing the use of ***preferred providers***, the composition of the provider network, and whether and under what circumstances coverage is provided for out-of-network services; any conditions or limits on the selection of a ***primary care provider*** or providers of specialty medical care; and any condition or limits applicable to obtaining emergency medical care.

Utilization Review (Precertification):

Utilization Review is the process of evaluating if services, supplies or treatment are ***medically necessary*** and appropriate to help ensure cost-effective care, also known as precertification. ***Utilization Review*** can eliminate unnecessary services, ***hospitalizations,*** and shorten ***confinements*** while improving quality of care and reducing costs to the ***covered person*** and the ***Plan.*** Certain procedures and/or treatments require precertification. Failure to comply with the precertification procedures may result in a reduction of benefits or loss of benefits. Refer to the sections entitled, *Schedule of Benefits* and *Utilization Review* for complete details.

Loss of Benefits:

For detailed information regarding a person being ineligible for benefits through reaching ***maximum benefit*** levels, reduction in benefits, or termination of coverage**,** refer to the following sections:

Schedule of Benefits
Utilization Review
Termination of Coverage
Plan Exclusions

Third Party Liability Reimbursement/Subrogation:

The ***Plan*** maintains the right to seek reimbursement on its own behalf: the right of subrogation. The ***Plan*** also reserves the right to reimbursement upon a ***covered person's*** (a covered ***employee*** or a covered dependent) receipt of settlement, judgment, or award: the right of reimbursement. The ***Plan*** reserves the right of recovery, either by subrogation or reimbursement, for ***covered expenses*** payable by the ***Plan*** which are a result of ***illness*** or ***injury***. The ***Plan*** shall be reimbursed from the first monies recovered as the result of judgment, settlement or otherwise. (This is known as "Pro tanto" subrogation.) This right includes the ***Plan's*** right to receive reimbursement from uninsured or underinsured motorist coverage and no-fault coverage.

Accepting benefits from this ***Plan*** automatically assigns to it any rights the ***covered person*** may have to recover benefits from any party, including an insurer or another group health program. This right of recovery allows the ***Plan*** to pursue any claim which the ***covered person*** may have against any party, group health program or insurer, whether or not the ***covered person*** chooses to pursue that claim. This includes a right to recover from no-fault auto insurance carriers in a situation where no third party may be liable, or from any uninsured or underinsured motorist coverage where the recovery was triggered by the actions of a party which caused or contributed to the payment of benefits under this ***Plan.*** This also includes a right to recover from amounts the ***covered person*** received from workers' compensation, whether by judgment or settlement, where the ***Plan*** has paid benefits prior to a determination that the medical expenses arose out of and in the course of employment. Payment by workers' compensation will be presumed to mean that such a determination has been made.

Failure to reimburse the ***Plan*** for ***covered expenses*** paid by the ***Plan*** that were also paid by a third party otherwise responsible shall result in a reduction of future claim benefits of a ***covered person*** up to the aggregate amount the ***Plan*** has paid.

For detailed information on the ***Plan's*** rights under third party liability reimbursement and/or subrogation, refer to the section entitled, *Third Party Liability Reimbursement/Subrogation.*

Plan Termination:

The ***employer*** reserves the right to terminate the ***Plan***, in whole or in part, at any time. Upon termination, the rights of the ***covered persons*** to benefits are limited to claims ***incurred*** up to the date of termination. Any termination of the ***Plan*** will be communicated to the ***covered persons.***

Upon termination of this ***Plan,*** all claims ***incurred*** prior to termination, but not submitted to either the ***employer*** or ***claims processor*** within three (3) months of the ***effective date*** of termination of this ***Plan,*** will be excluded from any benefit consideration.

The allocation and disposition of any assets of the ***Plan*** upon termination of the ***Plan*** shall include appropriate payment of ***Plan*** expenditures including administrative fees and ***covered expenses*** for ***covered persons***.

Plan Modification/Amendment:

The ***employer*** may modify or amend the ***Plan*** from time to time at its sole discretion, and such amendments or modifications which affect ***covered persons*** will be communicated to the ***covered persons*** within sixty (60) days after the adoption of the amendment***.*** Any such amendments shall be in writing, setting forth the modified provisions of the ***Plan,*** the ***effective date*** of the modifications, and shall be signed by the ***employer's*** designee. Such modification or amendment shall be duly incorporated in writing into the master copy of the ***Plan*** on file with the ***employer,*** or a written copy thereof shall be deposited with such master copy of the ***Plan.***

Continuation of Coverage (COBRA) Information:

Once coverage under the ***Plan*** becomes effective for ***employees*** and their ***dependents,*** those individuals have the right to continue coverage under the ***Plan*** should loss of coverage occur due to specified reasons. This period of continuation of coverage has specified time limitations, depending upon the reason for loss of coverage. ***Employees*** and ***dependents*** who elect continuation of coverage under this provision are responsible for payment of the full costs of

the ***Plan,*** including a two percent (2%) administration charge. For detailed information concerning continuation of coverage, refer to the section entitled, *Continuation of Coverage.*

Source of Plan Contributions:

Contributions for ***Plan*** expenses are obtained from the ***employer*** and ***employee*** and from the covered ***employees*** for their covered ***dependents.*** The ***employer*** evaluates the costs of the ***Plan*** based on projected ***Plan*** expenses and determines the amount to be contributed by the ***employer*** and the amount to be contributed by the covered ***employees.***

Funding Method:

The ***employer*** pays ***Plan*** benefits and administration expenses directly from general assets. Contributions received from ***covered persons*** are used to cover ***Plan*** costs and are expended immediately.

Ending Date of Plan Year:

June 30th

Procedures for Filing Claims:

The following is intended to provide a general overview of the procedures for filing a claim, providing notice of benefit determinations, including "pre-service claims" known as ***Utilization Review (precertification)***, and appealing denied claims. For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled, *Claim Filing Procedures.* For detailed information on how to go through the ***Utilization Review*** process, or file an appeal on a decision from the ***Utilization Review Organization***, refer to the section entitled *Utilization Review.* The designated ***claims processor*** is: Summit Administration Services, Inc., P. O. Box 25160, Scottsdale, AZ 85255, 1-888-690-2020.

General Requirements:

1. The ***Plan*** may not have any provision that unduly inhibits or hampers claims filing or processing.

2. The ***Plan*** may not prohibit an authorized representative from acting on behalf of a ***covered person***.

3. The ***Plan*** must have administrative processes and safeguards to ensure that claim decisions are made based upon plan documents and have been consistently applied for similarly situated individuals.

4. Upon a ***covered person's*** request after a claim denial, the ***Plan*** must provide any relevant information verifying that it complied with its procedures.

Specific Requirements:

1. Claim Deficiencies

   A. Urgent Care Claims: If the claim is incomplete, the ***Plan*** must notify the ***covered person*** of the deficiency and specify what information is missing within seventy-two (72) hours after receipt of the claim. The ***covered person*** shall be afforded a reasonable amount of time, but no less than forty-eight (48) hours to provide the missing information. The ***Plan*** must then make the decision no more than forty-eight (48) hours after the earlier of: the ***Plan's*** receipt of the missing information or the end of the additional period of time.

   B. Pre-service Claims: In the event a ***covered person*** or his authorized representative submits a pre-service claim that does not comply with the ***Plan's*** claims procedures, within five (5) calendar days of the discovery of the defect, the ***Plan*** must provide the ***covered person*** or his representative with oral or written notice of the deficiency and the steps needed to cure it. If the

covered person or his representative requests such a notice to be in writing, the ***Plan*** must do so. The ***covered person*** shall have no less than forty-five (45) days to provide the information.

2. Timing of Notification of Benefit Determination The ***covered person*** shall be notified of the ***Plan's*** benefit determination on review as follows:

   A. Urgent Care Claims (precertification): If the ***physician*** classifies a claim as urgent, the ***Plan*** must recognize the claim as urgent. ***Covered persons*** must be notified of a benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after the receipt of the claim.

   B. Pre-service Claims: The ***Plan*** must make a benefit determination within fifteen (15) days after receipt of request from a ***covered person***. This time period may be extended for another fifteen (15) days if it is necessary because of matters beyond the ***Plan's*** control, and if the ***Plan*** notifies the ***covered person*** of those circumstances and the expected date of the decision before the end of the first fifteen (15) day period.

   C. Concurrent Care Claims: When a ***covered person*** requests extension of an on-going course of treatment beyond that which the ***Plan*** has approved, the ***Plan*** must make a decision regarding the extension within seventy-two (72) hours after receipt of the request and notify the ***covered person*** of the decision, provided the request for the extension was made at least seventy-two (72) hours before the end of the treatment which was already approved.

   D. Post-service Claims: The ***Plan*** shall notify the ***covered person*** of an adverse benefit determination not more than thirty (30) days after receipt of the claim by the ***Plan***. This time period may be extended for fifteen (15) days if it is necessary because of matters beyond the ***Plan's*** control, and if the ***Plan*** notifies the ***covered person*** of those circumstances and the expected date of decision before the end of the thirty (30) day period. This Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. The ***employee*** will be allowed up to forty-five (45) calendar days from receipt of the Notice of Extension to provide the additional information. The ***Plan*** will then make a claim determination within a reasonable period but not later than fifteen (15) calendar days from the date the ***Plan*** receives the additional information.

3. Appeals. The ***Plan*** may not require a ***covered person*** to file more than two (2) appeals before he is able to file a lawsuit.

   A. Urgent Care Claims (precertification): If certification of ***medical necessity*** is denied and the ***covered person*** appeals the denial, the ***Plan*** must render a review decision as soon as possible, but no more than seventy-two (72) hours after receiving the appeal.

   B. Pre-service Claims (precertification): If certification of ***medical necessity*** is denied and the ***covered person*** appeals the denial, the ***Plan*** must render a review decision within thirty (30) days after receiving the appeal. If the ***Plan*** provided for two (2) levels of review, both appeals must be decided within that thirty (30) day time period, and one must be decided within fifteen (15) days after receipt of the appeal. The ***covered person*** has 180 days to appeal a denial.

   C. Concurrent Care Claims: If the ***Plan*** has approved an on-going course of treatment, and then determines that such treatment should be reduced or terminated, the ***Plan*** must notify the ***covered person*** of this decision far enough in advance of the reduction or termination to allow the ***covered person*** to appeal the decision and obtain a review before the reduction or termination takes effect. This does not apply to an amendment or termination of the ***Plan.***

D. Post-service Claims: If a claim for benefits is denied by the ***Plan*** and the ***covered person*** appeals the denial, the ***Plan*** must render a review decision within sixty (60) days after receiving the appeal. If the ***Plan*** provides for two levels of review, both appeals must be decided within the sixty (60) day time period, and one must be decided within thirty (30) days following receipt of the appeal. The ***covered person*** has 180 days to appeal a claim denial.

Internal and External Appeal Process:

Refer to *Claim Filing Procedure, Internal and External Appeal Process* for more details.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act:

Under federal law, group health plans offering group health coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the ***Plan*** may pay for a short stay if the attending provider (e.g. the ***physician,*** nurse midwife, or physician assistant,) after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, group health plans may not set the level of benefits or 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 group health 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. However, to use certain providers or facilities, or to reduce the out-of-pocket cost, a ***covered person*** may be required to obtain precertification. For information on precertification, refer to the section entitled, *Utilization Review.*

Privacy Rights:

This ***Plan*** complies with the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). ***Covered Persons*** have the following rights under the HIPAA Privacy Rule:

1. The right to request restriction on the uses and disclosures of medical information. The ***employer*** is not required to agree to the requested restriction if the request is deemed unreasonable or would hinder the routine processing of claims.

2. The ***employer*** must give a ***covered person*** the opportunity to inspect or obtain copies of their medical information with exception for psychotherapy notes and information compiled for use in a civil, criminal or administrative action.

3. The ***employer*** must provide ***covered persons*** the opportunity to amend their medical information for as long as the ***employer*** maintains it for the ***Plan***. The ***employer*** may deny an individual's request for amendment if it determines that the medical information was not created by the ***Plan.***

SCHEDULE OF BENEFITS

The following *Schedule of Benefits* is designed as a quick reference. For complete provisions of the ***Plan's*** benefits, refer to the following sections: *Utilization Review, Preferred Provider Organization, Medical Expense Benefit, Prescription Drug Program* and *Plan Exclusions.*

A complete listing of ***preferred providers*** can be obtained from the Human Resources Department. Limitations are combined maximums for ***preferred*** and ***nonpreferred*** providers. Certain words and terms used herein are defined and are shown in ***bold and italics*** throughout the document. Refer to the section entitled, *Definitions.* All ***Plan*** benefits are calculated based on a "benefit year." The benefit year is January 1st through December 31st.

MEDICAL BENEFITS

Coinsurance:

The ***Plan*** pays the percentage listed on the following pages for ***covered expenses*** at the ***customary and reasonable amount*** for ***nonpreferred providers***, or the percentage of the ***negotiated rate*** for ***preferred providers*** (no deductible). This is known as the ***Plan's coinsurance.*** The ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the ***negotiated rate*** for ***preferred providers.*** For ***nonpreferred providers***, the ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the billed amount

For example, if the ***Plan*** pays fifty percent (50%) of the ***customary and reasonable amount*** for ***nonpreferred provider*** services, the ***covered person*** is responsible for the remaining fifty percent (50%) of the ***customary and reasonable amount.*** However, any amount that the ***nonpreferred provider*** bills in excess of the ***customary and reasonable amount*** is not a ***covered expense*** of the ***Plan*** and does not apply toward the out-of-pocket expense limit. The ***covered person*** is responsible to pay any amount billed by a ***nonpreferred provider*** in excess of the ***customary and reasonable amount.***

Note
Services provided by a *non-preferred provider* will be paid at fifty percent (50%) of the *customary and reasonable amount* after a $2,000 per person deductible has been satisfied. *Nonpreferred provider* services will never reach an out-of-pocket maximum and will never be paid at one hundred percent (100%) *coinsurance.*

BENEFIT DESCRIPTION & BENEFIT LIMITATION The ***benefit year*** is January 1st through December 31st.	PREFERRED PROVIDER The ***Plan*** shall pay the listed percentage of the ***negotiated rate.***

Precertification Penalty Failure to obtain precertification for services requiring precertification shall result in a $300 penalty deductible applying to ***covered expenses*** first, then any applicable ***benefit year*** deductible, then the ***Plan's coinsurance*** applies. No benefits payable for transplants without precertification.	
Benefit Year **Deductible** Individual (Per Person) Family (Aggregate)	 $0 $0
Out-of-Pocket Expense Limit Per *Benefit Year*: **(**includes medical and prescription ***copays*** and ***coinsurance*****)** Individual Family (Aggregate) Refer to *Medical Expense Benefit,* ***Benefit Year*** *Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit.	 $6,000 $12,000
Inpatient Hospital Precertification required.	100% after $250 ***copay*** per admission
Outpatient Hospital/Ambulatory Surgical Facility Specified procedures require precertification. See *Utilization Review.*	100% after $100 ***copay***
Ambulance Service	100%
Emergency Room Services	100% after $150 ***copay***
Physician's Services Home & Inpatient Visit Office Visit Primary Care Physician Specialist Surgery - Physician's Office Surgery - Other Pathology Anesthesiology Radiology	 100% 100% after $20 ***copay*** 100% after $40 ***copay*** 100% 100% 100% 100% 100%
Extended Care Facility Precertification required. Limitation: 90 days ***maximum benefit*** per ***benefit year***	100% after $250 ***copay***
Home Health Care Precertification required.	100%
Hospice Care Precertification required.	100%
Durable Medical Equipment	100%
Preventive Care Services All preventive care services as recommended by the U.S. Preventive Services Task Force	100% For a complete listing, go to: www.healthcare.gov/coverage/preventive-care-benefits

BENEFIT DESCRIPTION & BENEFIT LIMITATION The ***benefit year*** is January 1st through December 31st.	PREFERRED PROVIDER The ***Plan*** shall pay the listed percentage of the ***negotiated rate.***
Pediatric Health Care	100% For a complete listing, go to: www.healthcare.gov/coverage/preventive-care-benefits
Immunizations	100% For a complete listing, go to: www.healthcare.gov/coverage/preventive-care-benefits
Preventive Care: Well Woman Preventive Services Includes: Well Woman Visits; Screening for gestational diabetes; Human Papillomavirus testing; counseling for sexually transmitted infections; counseling & screening for human immune-deficiency virus; contraceptive methods & counseling; breast-feeding support, supplies and counseling; screening & counseling for interpersonal & domestic violence; Routine Mammogram	100% For a complete listing, go to: www.healthcare.gov/coverage/preventive-care-benefits %
Mental & Nervous Disorders/Chemical Dependency ***Inpatient*** Services Precertification required Outpatient Services First 10 visits Thereafter	100% after $250 ***copay*** 100% after $10 ***copay*** 100%
Therapy Services (Radiology, Chemotherapy, Dialysis)	100%
Rehabilitative Services (Physical, Speech, Occupational) Limited to 20 visits per ***benefit year*** for ***outpatient*** physical and occupational therapy combined Limited to 20 visits per ***benefit year*** for ***outpatient*** speech therapy Additional benefits for services of a ***preferred provider*** that exceed the annual maximum may be available if determined to be ***medically necessary*** by the ***Utilization Review Organization.*** Such benefits shall be payable at 50% up to a maximum out-of-pocket expense of $500. After the maximum out-of-pocket has been reached, benefits shall be payable at 100%.	100%
Chiropractic Care Limitation: 20 visits ***maximum benefit*** per ***benefit year***	100% after $40 ***copay***

BENEFIT DESCRIPTION & BENEFIT LIMITATION The ***benefit year*** is January 1st through December 31st.	PREFERRED PROVIDER The ***Plan*** shall pay the listed percentage of the ***negotiated rate.***
Prosthetics	100%
Dental Injury	100%
Transplants **Limited to $200 per day/$10,000 while covered by this Plan for travel and lodging with no deductible or coinsurance**	100%
Temporomandibular Joint Dysfunction Limited to $1,000 ***maximum benefit*** while covered by this ***Plan.***	100%
Diagnostic Testing, Lab and X-ray Services	100%
Neuropsychological and Cognitive Testing Limited to 10 hours of testing per calendar year	100%
Cataract Surgery Limited to $500 ***maximum benefit*** for initial pair of eyeglasses or contacts following surgery	100%
Hearing Services and Devices Limited to $25,000 while covered by this ***Plan.***	100%
All Other Covered Expenses	100%

PRESCRIPTION DRUG PROGRAM

POINT OF PURCHASE	BENEFIT	SUPPLY LIMITATION
Participating Pharmacy	100% ***Plan*** payment after ***copay****:* Contraceptives & other non-prescription drugs as mandated by the Patient Protection and Affordable Care Act: $0 ***copay*** Generic & Diabetic Supplies & Drugs: $5 ***copay*** Formulary Brand Name: $25 ***copay*** Non-Formulary Brand Name: $75 ***copay*** Specialty Drugs: $200 ***copay***	30 day supply
Nonparticipating Pharmacy	Not Covered	
Mail Order	Contraceptives & other non-prescription drugs as mandated by the Patient Protection and Affordable Care Act: $0 ***copay*** Generic & Diabetic Supplies & Drug $5 ***copay*** Formulary Brand Name: $25 ***copay*** Non-Formulary Brand Name: $75 ***copay*** Specialty Drugs: $200 ***copay***	90 day supply
Out-of-Pocket Expense Limit	The ***copays*** under the *Prescription Drug Program* shall apply toward the *Medical Expense Benefit,* ***preferred provider*** Out-of-Pocket Expense Limit. Refer to Out-of-Pocket Expense Limit Exclusions for a listing of charges not applicable.	

UTILIZATION REVIEW

Utilization review is the process of evaluating if services, supplies or treatment are ***medically necessary*** and appropriate to help ensure cost-effective care. ***Utilization Review*** can eliminate unnecessary services, ***hospitalizations,*** and shorten ***confinements*** while improving quality of care and reducing costs to the ***covered person*** and the ***Plan.***

Certification of ***medical necessity*** and appropriateness by the ***Utilization Review Organization*** does not establish eligibility under the ***Plan*** nor guarantee benefits.

PRECERTIFICATION

Hospital/Outpatient Surgery

All medical, surgical, psychiatric, substance abuse ***hospital*** admissions, including acute ***hospital*** admissions long term acute admissions. Acute rehabilitation, acute detoxification and specified ***outpatient hospital/ambulatory surgical facility*** procedures are to be certified in advance of the proposed ***confinement*** or surgery (precertification) by the ***Utilization Review Organization,*** except for ***emergencies***. The ***covered person*** or their representative should call the ***Utilization Review Organization*** prior to admission. ***Emergency hospital*** admissions are to be reported to the ***Utilization Review Organization*** within forty-eight (48) hours following admission, or on the next business day after admission.

Covered persons should contact the Utilization Review Organization by calling: 1-800-944-9401

Group health plans generally may not, under federal law, restrict benefits for any ***hospital*** length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. If delivery occurs in the ***hospital,*** the 48-hour period, or 96-hours, begins at the time of delivery. If delivery occurs outside the ***hospital*** and is later ***confined*** to the ***hospital*** in connection with childbirth, the period begins at the time of the ***hospital*** admission. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law require that a provider obtain authorization from the ***Plan*** for prescribing a length of stay not in excess of the above periods. If a newborn remains hospitalized beyond the time frames specified above, the ***confinement*** must be precertified.

After admission to the ***hospital,*** the ***Utilization Review Organization*** will continue to evaluate the ***covered person's*** progress through ***concurrent review*** to monitor the length of ***confinement*** and ***medical necessity*** of treatment. If the ***Utilization Review Organization*** disagrees with the length of ***confinement*** recommended by the ***physician,*** the ***covered person*** and the ***physician*** will be advised. If the ***Utilization Review Organization*** determines that continued ***confinement*** is no longer necessary, additional days will not be certified. **Benefits payable for days not certified as *medically necessary* by the *Utilization Review Organization* shall be denied.**

However, in the event that a ***retrospective review***, (a review completed after the event), determines that the hospitalization or surgery did not exceed the amount that would have been approved had the precertification been completed, there will be no penalty assessed and the amount of any deductible and/or ***coinsurance*** will count towards the satisfaction of the ***covered person's*** maximum out-of-pocket expense.

PRECERTIFICATION PENALTY

For the purpose of determining benefits payable if certification of ***medical necessity*** is not obtained, ***covered expenses*** shall be subject to a three hundred dollar ($300) penalty deductible applying to ***covered expenses*** first, then any applicable ***benefit year*** deductible, then the ***Plan's coinsurance*** applies. In addition no benefits shall be payable for transplants if precertification is not obtained.

NOTIFICATION DEFICIENCIES

Urgent Care Claims: If the request for precertification is incomplete, the ***Utilization Review Organization*** must notify the ***covered person*** of the deficiency and specify what information is missing within seventy-two (72) hours after receipt of the claim. The ***covered person*** shall be afforded a reasonable amount of time, but no less than forty-eight (48) hours to provide the missing information. The ***Plan*** must then make the decision no more than forty-eight (48) hours after the earlier of: the ***Plan's*** receipt of the missing information or the end of the additional period of time.

Pre-service Claims: In the event a ***covered person*** or his authorized representative submit a pre-service claim that does not comply with the ***Plan's*** claims procedures, within five (5) calendar days of the discovery of the defect, the ***Plan*** must provide the ***covered person*** or his representative with oral or written notice of the deficiency and the steps needed to cure it. If the ***covered person*** or his representative requests such a notice to be in writing, the ***Plan*** must do so. The ***covered person*** shall have no less than forty-five (45) days to provide the information.

TIMING OF NOTIFICATION

The ***covered person*** shall be notified of the ***Plan's*** benefit determination on review as follows:

Urgent Care Claims (precertification): If the ***physician*** classifies a claim as urgent, the ***Plan*** must recognize the claim as urgent. ***Covered persons*** must be notified of decisions as soon as possible, but no more than seventy-two (72) hours after receipt of the claim.

Pre-service Claims: The ***Plan*** must make a benefit determination within fifteen (15) days after receipt of request from a ***covered person***. This time period may be extended for another fifteen (15) days if it is necessary because of matters beyond the ***Plan's*** control, and if the ***Plan*** notifies the ***covered person*** of those circumstances and the expected date of the decision before the end of the first fifteen (15) day period.

Concurrent Care Claims: When a ***covered person*** requests extension of an on-going course of treatment beyond that which the ***Plan*** has approved, the ***Plan*** must make a decision regarding the extension within twenty-four (24) hours after receipt of the request and notify the ***covered person*** of the decision, provided the request for the extension was made at least twenty-four (24) hours before the end of the treatment which was already approved.

PRECERTIFICATION APPEAL PROCESS

In the event certification of ***medical necessity*** is denied by the ***Utilization Review Organization,*** the ***covered person*** may appeal the decision. The ***covered person*** may call the ***Utilization Review Organization*** for more information concerning the appeal process.

Urgent Care Claims (precertification): If certification of ***medical necessity*** is denied and the ***covered person*** appeals the denial, the ***Utilization Review Organization*** must render a review decision as soon as possible, but no more than seventy-two (72) hours after receiving the appeal.

Pre-service Claims (precertification): If certification of ***medical necessity*** is denied and the ***covered person*** appeals the denial, the ***Utilization Review Organization*** must render a review decision within thirty (30) days after receiving the appeal. If two (2) levels of review are provided, both appeals must be decided within that thirty (30) day time period, and one must be decided within fifteen (15) days after receipt of the appeal. The ***covered person*** has 180 days to appeal a denial.

Concurrent Care Claims: If the ***Utilization Review Organization*** has approved an on-going course of treatment, and then determines that such treatment should be reduced or terminated, the ***Utilization Review Organization*** must notify the ***covered person*** of this decision far enough in advance of the reduction or termination to allow the ***covered person*** to appeal the decision and obtain a review before the reduction or termination takes effect. This does not apply to an amendment or termination of the ***Plan.***

CASE MANAGEMENT

In cases where the ***covered person's*** condition is expected to be or is of a serious nature, the ***Utilization Review Organization*** may arrange for review and/or ***Case Management*** services from a professional qualified to perform such services. The ***employer*** shall have the right to alter or waive the normal provisions of this ***Plan*** when it is reasonable to expect a cost effective result without a sacrifice to the quality of care.

Case Management will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that ***covered person*** or any other ***covered person.***

ALTERNATIVE CARE

The ***Utilization Review Organization*** may recommend (or change) alternative methods of medical care or treatment, equipment or supplies that are not ***covered expenses*** under this ***Plan;*** or are ***covered expenses*** under this ***Plan*** but on a basis that differs from the alternative recommended by the ***Utilization Review Organization.*** The ***Plan*** will recognize such alternative services as ***covered expenses.***

Alternative care will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that ***covered person*** or any other ***covered person.***

PREFERRED PROVIDER OR NONPREFERRED PROVIDER

Covered persons have the choice of using either a ***preferred provider*** or a ***nonpreferred provider.***

PREFERRED PROVIDERS

A ***preferred provider*** is a ***physician, hospital*** or ancillary service provider which has an agreement in effect with the ***Preferred Provider Organization*** (PPO) to accept a reduced rate for services rendered to ***covered persons.*** This is known as the ***negotiated rate.*** The ***preferred provider*** cannot bill the ***covered person*** for any amount in excess of the ***negotiated rate.*** Because the ***covered person*** and the ***Plan*** save money when services, supplies or treatment are obtained from providers participating in the ***Preferred Provider Organization,*** benefits are usually greater than those available when using the services of a ***nonpreferred provider. Covered persons*** should contact the Human Resources Department for a current listing of ***preferred providers.***

Advantages of Using a Preferred Provider

1. The ***covered person*** is not billed for charges that exceed the ***negotiated rate.***

2. The ***covered person*** saves money on health care costs because (A) of the reduced rate (***negotiated rate***) and, (B) the ***Plan*** is able to provide greater benefits from ***preferred providers***.

How to Use the Preferred Providers

1. When the ***covered person*** needs to see the ***physician*** or other health care provider, the directory of ***preferred providers*** will supply a listing of providers in the area. The ***covered person*** should contact the provider to verify the provider is still a member of the ***Preferred Provider Organization.*** It is possible that some providers may have been added to or deleted from the ***Preferred Provider Organization.*** If the provider is still a member, an appointment can be scheduled.

2. Upon arrival for the scheduled appointment, the ***covered person*** should show the ***participating provider*** the identification card. The ***participating provider's*** billing office will submit the claim on behalf of the ***covered person*** to the ***claims administrator***.

3. If additional services from other providers are required, such as diagnostic x-ray and laboratory, the ***covered person*** should ask the ***participating provider*** to ensure such other provider is also a ***participating provider.***

MEDICARE-LIKE RATE PRICING

As permitted under C.F.R. Title 42, Part 136, Subpart D, benefits payable for ***covered expenses*** for ***inpatient*** and ***outpatient hospital*** services which qualify as expenses under the ***Medicare***-Like Rate Program shall be processed at the ***Medicare***-Like Rate pricing or the ***preferred provider negotiated rate,*** whichever is less.

NONPREFERRED PROVIDERS

A ***nonpreferred provider*** does not have an agreement in effect with the ***Preferred Provider Organization.*** This ***Plan*** will allow only the ***customary and reasonable amount*** as a ***covered expense.*** The ***Plan*** will pay its percentage of the ***customary and reasonable amount*** for the ***nonpreferred provider*** services, supplies and treatment. The ***covered person*** is responsible for the remaining balance. This results in greater out-of-pocket expenses to the ***covered person.***

In the event the total charges by a ***nonpreferred provider*** are less than the ***preferred provider negotiated rate,*** or if the ***nonpreferred provider*** agrees to accept less or the equivalent of the ***preferred provider negotiated rate,*** the ***claims processor*** may, in its discretion on behalf of the ***Plan,*** pay the ***nonpreferred provider*** at the ***preferred provider*** level of benefits identified in the section entitled *Schedule of Benefits.*

REFERRALS

Referrals to a ***nonpreferred provider*** are covered as ***nonpreferred provider*** services, supplies and treatments. It is the responsibility of the ***covered person*** to ensure services to be rendered are performed by ***preferred providers*** in order to receive the ***preferred provider*** level of benefits.

EXCEPTIONS

The following listing of exceptions represents services, supplies or treatments rendered by a ***nonpreferred provider*** where ***covered expenses*** shall be payable at the ***preferred provider*** level of benefits:

1. Radiologist or pathologist services for interpretation of x-rays and laboratory tests rendered by a ***nonpreferred provider*** when the ***facility*** rendering such services is a ***preferred provider.***

2. While confined to a ***preferred provider hospital,*** the ***preferred provider physician*** requests a consultation from a ***nonpreferred provider.***

3. ***Nonpreferred*** anesthesiologist if the operating surgeon is a ***preferred provider.***

4. Diagnostic laboratory and pathology tests referred to a ***nonpreferred provider*** by a ***preferred provider.***

5. If a ***covered person*** is out of the EPO/PPO service are and has a medical ***emergency*** requiring immediate care, including related services such as ancillary providers.

6. ***Medically necessary*** services, supplies and treatments not available through any ***preferred provider.***

MEDICAL EXPENSE BENEFIT

This section describes the ***covered expenses*** of the ***Plan.*** All ***covered expenses*** are subject to applicable ***Plan*** provisions including, but not limited to: deductible, ***copay, coinsurance*** and ***maximum benefit*** provisions as shown in the *Schedule of Benefits*, unless otherwise indicated. Any expenses ***incurred*** by the ***covered person*** for services, supplies or treatment provided will not be considered ***covered expenses*** by this ***Plan*** if they are greater than the ***customary and reasonable amount*** or ***negotiated rate,*** as applicable**.** The ***covered expenses*** for services, supplies or treatment provided must be recommended by a ***physician*** or ***professional provider*** and be ***medically necessary*** care and treatment for the ***illness*** or ***injury*** suffered by the ***covered person.*** Specified preventive care expenses will be covered by this ***Plan.***

COPAY

The ***copay*** is the amount payable by the ***covered person*** for certain services, supplies or treatment**.** The service and applicable ***copay*** are shown on the *Schedule of Benefits.* The ***copay*** must be paid each time a treatment or service is rendered. .

COINSURANCE

The ***Plan*** pays a specified percentage of ***covered expenses*** at the ***customary and reasonable amount*** for ***nonpreferred providers***, or the percentage of the ***negotiated rate*** for ***preferred providers***. That percentage is specified in the *Schedule of Benefits*. The ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the ***negotiated rate*** for ***preferred providers.*** For ***nonpreferred providers***, the ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the billed amount.

BENEFIT YEAR OUT-OF-POCKET EXPENSE LIMIT

Individual *Benefit Year* Out-of-Pocket Expense Limit

After the ***covered person*** has incurred an amount equal to the out-of-pocket expense limit listed in the *Schedule of Benefits* for ***covered expenses,*** including the ***covered expenses*** under *Medical Expense Benefit* for ***preferred provider benefit year copays*** and ***coinsurance***, as well as the *Prescription Drug Program* ***copays,*** the ***Plan*** will begin to pay 100% of the ***covered expenses*** for the remainder of the ***benefit year.***

Family *Benefit Year* Out-of-Pocket Expense Limit

After a covered family has incurred an combined amount equal to the family out-of-pocket expense limit listed on the *Schedule of Benefits* for ***covered expenses,*** including ***copays***, the ***Plan*** will begin to pay one hundred percent (100%) for ***covered expenses*** for all covered family members for the remainder of the ***benefit year***.

Out-of-Pocket Expense Limit Exclusions

The following items do not apply toward satisfaction of the ***benefit year*** out-of-pocket expense limit:

1. Expenses for services, supplies and treatments not covered by this ***Plan,*** to include charges in excess of the ***customary and reasonable amount.***

2. Expense ***incurred*** as a result of failure to obtain precertification.

MAXIMUM BENEFIT

The *Schedule of Benefits* contains separate ***maximum benefit*** limitations for specified conditions. Any separate ***maximum benefit*** will include all such benefits paid by the ***Plan*** for the ***covered person*** during any and all periods of coverage under this ***Plan.***

COVERED EXPENSES

AMBULANCE SERVICES

Ambulance services must be by a licensed air or ground ambulance. ***Covered expenses*** shall include:

1. Ambulance services for air or ground transportation for the ***covered person*** from the place of ***injury*** or serious medical incident to the nearest ***hospital*** where treatment can be given.

2. Ambulance service is covered in a non-emergency situation only to transport the ***covered person*** to or from a ***hospital*** or between ***hospitals*** for required treatment when such treatment is certified by the attending ***physician*** as ***medically necessary.*** Such transportation is covered only from the initial ***hospital*** to the nearest ***hospital*** qualified to render the special treatment.

3. ***Emergency*** services actually provided by an advance life support unit, even though the unit does not provide transportation.

B-12 INJECTIONS

Covered expenses shall include charges for B-12 injections when there is documented deficiency related to malabsorption or impaired utilization and unresolved with oral Vitamin B-12. B-12 therapy is reasonable and necessary when pathologic conditions preclude adequate B-12 absorption from food.

B-12 injections are ***medically necessary*** only for ***covered persons*** with any one of the following diagnoses and conditions:

a. Anemia
   - Pernicious anemia (Addision anemia, Biermer's anemia)
   - Macrocytic anemia
   - Fish tapeworm anemia
   - Megaloblastic anemia

b. Gastrointestinal disorders
   - Malasorption syndromes such as sprue
   - Idiopathic steatorrhea
   - Other malabsorption
   - Surgical or mechanical disorders such as:
     - resection of the small intestine
     - intestinal strictures
     - intestinal anastomosis
     - blind loop syndrome
     - gastrectomy (subtotal or total)

c. Neuropathy
   - Posterolateral sclerosis
   - Neuropathies associated with pernicious anemia (Addison anemia, Biermer's anemia)
   - Acute phase or acute exacerbation of a neuropathy due to malnutrition or alcoholism

d. Methylamalonic aciduria

e. Homocystinuria

f. Retrobulbar neuritis associated with heavy smoking, also known as tobacco amblyopia

g. Dementia secondary to Vitamin B12 deficiency

h. ***Covered persons*** receiving pemetrexed (Alimta) (see CPB 687)

Physician administration of Vitamin B-12 injections is considered ***medically necessary*** for the diagnoses and conditions listed above.

Administration of Vitamin B-12 injections for more than two (2) to three (3) is subject to review to ascertain if deficiency/abnormalities have improved and to decide whether continued treatment is ***medically necessary.***

Measurement of serum homocystine is considered ***medically*** in persons with borderline B-12 deficiency, where the results will impact the patients management.

BARIATRIC SURGERY

Covered expenses shall include bariatric surgery (restrictive gastrointestinal surgery, adjustable gastric band system sleeve procedures and any other FDA-approved procedure). Such services shall be processed based on clinical criteria and will be considered ***medically necessary*** with documentation of all of the following:

a. The individual is morbidly obese as defined by one (1) of the following:
   - Body Mass Index (BMI) of forty (40) or greater
   - Body Mass Index (BMI) of fifty (50) or greater for biliopancreatic diversion with duodenal switch Procedure
   - Body Index of thirty-five (35) or greater with any of the following co-morbid conditions that are generally expected to be ameliorated (improved), reversed, or limited by this surgical treatment, for any eligible procedure.

b. Co-morbid conditions include, but are not limited to:
   - Cardiovascular disease
   - Coronary disease
   - Degenerative joint disease of weight bearing points
   - Diabetes mellitus
   - Documented sleep apnea
   - Pseudotumor cerebri
   - Pulmonary hypoventilation

c. Diagnosis of morbid obesity for five (5) years or more

d. Continuous participation in a ***physician-***supervised OR structures weight-loss program(s) for six (6) months or longer with a completion date in the preceding year as documented by the following:
   - Weight-loss program(s) in which the individual has participated reflects continuous involvement for a total of six (6) months, or longer and
   - Weight-loss program(s) is a ***physician-***supervised program or a structured weight-loss program (program must be identified and dates of participation must be outlined), and
   - Weight-loss program(s) include a diet and exercise program and/or pharmacological therapy.

e. Failure of non-surgical methods of weight loss as documented by the following:
   - Length of time individual was enrolled or participated in the weight-loss program(s) (program must be identified and dates of participation must be outlined), and
   - Regular follow-up visits documenting program (weekly, monthly) and
   - Results achieved, e.g. weight loss and time to regain the lost weight

f. Pre-operative clinical assessment and documentation must reflect a significant motivation and understanding of the risks associated with the intended surgery, as well as an understanding of the life-long restricted eating habits that will follow.

g. Clinical documentation must reflect a plan for active participation in both a pre-surgical instruction program and a post-surgical, post-operative or follow-up program. Clinical documentation must reflect participation in pre-operative nutritional counseling and that there is a plan in place for post-operative nutritional counseling as well.

h. Individual is eighteen (18) years of age or older.

i. Individual has no treatable condition that may be responsible for the morbid obesity; e.g. endocrine, metabolic, etc.

j. Individual has no significant liver, kidney or gastrointestinal disease.

k. Individual has no drug or alcohol abuse – must be abstinent for twelve (12) months or more if there is a history of drug or alcohol abuse.

l. Individual has no contraindications to surgery.

m. Individual has had an evaluation by a licensed psychologist or psychiatrist documenting the absence of significant psychopathology that may limit an individual's understanding of the procedure or ability to comply with medical/surgical recommendations (e.g. active ***chemical dependency,*** schizophrenia, borderline personality disorder, uncontrolled depression). Clinical documentation must substantiate approval by the attending clinician for the intended procedure if the individual has current symptoms of or is on maintenance for psychological or psychiatric disease.

n. Post-surgery follow-up office visits, related to the approved surgical procedure and outside of the global follow-up period are ***covered expenses,*** subject to the deductible, ***coinsurance*** or ***copay*** provisions.

Repeat bariatric surgeries shall be covered if current ***Plan*** guidelines for bariatric surgery are met.

Revisions to an eligible bariatric surgical procedure are also covered with documentation of any of the following conditions:

a. Anastomosis, leak at site
b. Anastomosis, marginal ulceration at site
c. Band erosion
d. External band slippage
e. Dehiscence/disruption of staple line
f. Disruption of operative wound
g. "Dumping" syndrome, severe
h. Esophageal dilation, symptomatic
i. Esophagitis confirmed on endoscopy or biopsy
j. Failed weight loss with weight regain due to stomal (pouch) dilation
k. Failed weight loss with esophageal dilation
l. Gastroesophageal reflux disease (GERT)
m. Hemorrhage or hematoma complicating a procedure
n. Intractable vomiting
o. Post-gastric surgery syndromes, e.g. post-gastrectomy syndrome, post-vagotomy syndrome
p. Pouch enlargement
q. Stomal stenosis or dilation documented by endscopy
r. Stricture(s) not amenable to balloon dilation

s. Unspecified and other post-surgical non-absorption, e.g. diarrhea following gastrointestinal surgery
t. Weight loss of twenty percent (20%) or more below the ideal body weight (based upon the 1996 Metropolitan Life Height and Weight tables for men/women)

NOTE: Revisions to a prior ineligible or ***investigational*** bariatric surgical procedure are considered a complication of a non-covered service and therefore no covered. Any bariatric surgery requires precertification.

BIRTHING CENTER

Covered expenses shall include services, supplies and treatments rendered at a ***birthing center*** provided the ***physician*** in charge is acting within the scope of his license and the ***birthing center*** meets all legal requirements.

Services of a midwife acting within the scope of his license or registration are a ***covered expense*** provided that the state in which such service is performed has legally recognized midwife delivery.

BOTULINUM TOXIN TYPE A (Botox) AND/OR BOTULINUM TOXIN TYPE B (MYOBLOC)

Covered expenses shall include ***medically necessary*** care, services and treatment for a ***covered person*** receiving Botox therapy with clinical documentation of conditions such as bleparospasm, post-facial (7^{th} cranial) nerve palsy synkinesis, hemifacial spasms, laryngeal spasm, focal dystonia, limb spasticity, cervical dystonia, esophageal achalsia and/or strabismus. Other specific medical conditions may be eligible for treatment when ***medically necessary*** and not excluded by the ***Plan.***

CARDIAC REHABILITATION PROGRAMS

Covered expenses shall include ***medically necessary*** Phase I or II cardiac rehabilitation programs when rendered:

(a) under the supervision of a ***physician;***

(b) in connection with a myocardial infarction, coronary occlusion, or coronary by-pass surgery;

(c) initiated within twelve (12) weeks after other treatment for the medical condition ends; and

(d) in a medical care ***facility*** as defined herein.

CHIROPRACTIC CARE

Covered expense includes services provided by a licensed M.D., D.O. or D.C. for consultation, x-rays and treatment, subject to the ***maximum benefit*** shown on the *Schedule of Benefits.*

CLINICAL TRIALS

Covered expenses for clinical trials shall be limited to a ***covered person*** who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either: (1) the referring health care professional is a ***preferred provider*** and has concluded that the ***covered person's*** participation in such trial would be appropriate; or (2) the ***covered person*** provides medical and scientific information establishing that the ***covered person's*** participation in such trial would be appropriate.

Covered expenses shall include routine services, supplies and treatment eligible for coverage under this ***Plan*** that would be required or covered if the ***covered person*** was receiving standard, non-investigational treatment. Such routine services, supplies and treatment include those by a ***physician***, diagnostic or laboratory tests, and other ***covered expenses*** provided during the course of treatment.

COSMETIC SURGERY/RECONSTRUCTIVE SURGERY

Cosmetic surgery or ***reconstructive surgery*** shall be a ***covered expense*** provided:

1. A ***covered person*** receives an ***injury*** as a result of an accident and, as a result, requires surgery. ***Cosmetic surgery*** or ***reconstructive surgery*** and treatment must be for the purpose of restoring the functions of the body which are lost or impaired due to ***injury.***

2. It is required to correct a congenital anomaly, for example, a birth defect.

3. It is required as the result of ***illness*** or previous surgery.

4. It is for reconstructive breast surgery necessary because of a mastectomy. A breast reduction surgery for any other reason is not a ***covered expense.***

5. It is for reconstructive breast reduction on the non-diseased breast to make it equal in size with the diseased breast following reconstructive surgery on the diseased breast.

DENTAL SERVICES

Covered expenses shall include repair of sound natural teeth or surrounding tissue provided it is the result of an ***injury.*** Treatment must begin within ninety (90) days of the date of such ***injury*** and be completed within twelve (12) months after the ***injury.*** Damage to the teeth as a result of chewing or biting shall not be considered an ***injury*** under this benefit. The surgical removal of bony or soft tissue impacted wisdom teeth shall be considered a ***covered expense.***

Subject to precertification, ***covered expenses*** shall include ***medically necessary*** dental restorations directly caused by a medical condition or which are required in order to perform a covered surgery or treatment. Prior to the start of any dental work under this provision, ***covered persons*** must contact the ***Utilization Review Organization*** for authorization and submit a proposed treatment plan to determine whether a dental service shall be deemed ***medically necessary.*** Any treatment not deemed ***medically necessary*** by the ***Utilization Review Organization*** shall not be deemed a ***covered expense.*** Services and treatments specifically excluded under this provision shall include, but are not limited to: dental implants and related services; occlusal rehabilitation and reconstructions; orthodontic services; routine dental care; repair and replacement of fixed or removable complete or partial dentures.

DIABETIC SUPPLIES AND EDUCATION

Covered expenses shall include diabetic education and training for ***covered persons*** diagnosed with diabetes to improve self-management. Diabetic education must be prescribed by the patient's ***physician*** as part of a comprehensive plan of care related to diabetes to ensure therapy, compliance, necessary skills and knowledge in the management of diabetes. Training must be done in person. The following diabetic supplies are covered when prescribed by a ***physician*****:**

a. blood glucose monitor (standard model);

b. blood glucose monitor for the legally blind;

c. test strips for glucose monitors and urine test strips;

d. injection aids;

e. syringes and lancets;

f. drawing-up devices and monitors for the visually impaired;

g. any other device, medication, equipment or supply for which coverage is required under ***Medicare,*** when purchased through an eligible ***durable medical equipment*** provider or as specifically listed as covered under the *Prescription Drug Program.*

DIAGNOSTIC SERVICES AND SUPPLIES

Covered expenses shall include services and supplies for diagnostic laboratory, pathology, ultrasound, nuclear medicine, magnetic imaging and x-ray.

DURABLE MEDICAL EQUIPMENT

Rental or purchase whichever is less costly of necessary ***durable medical equipment*** and is prescribed by a ***physician*** and required for therapeutic use by the ***covered person*** shall be a ***covered expense.*** Equipment ordered prior to the ***covered person's effective date*** of coverage is not covered, even if delivered after the ***effective date*** of coverage. Repair or replacement of purchased ***durable medical equipment*** which is ***medically necessary*** due to normal use or physiological change in the patient's condition will be considered a ***covered expense.*** Maintenance contracts for purchased equipment will be considered a ***covered expense.***

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the ***covered person's*** condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for equipment which would meet the ***covered person's*** medical needs.

EMERGENCY SERVICES/EMERGENCY ROOM

Coverage for emergency room treatment shall be paid in accordance with the *Schedule of Benefits* provided the condition meets the definition of ***emergency*** herein. Emergency room treatment for conditions that do not meet the definition of ***emergency*** or are received subsequent to the initial treatment shall be paid as non-***emergency*** charges. Services of ***nonpreferred providers*** shall be paid at the ***nonpreferred provider*** level.

EXTENDED CARE FACILITY

Extended care facility services, supplies and treatments shall be a ***covered expense*** provided:

1. The ***covered person*** was first confined in a ***hospital***;

2. The attending ***physician*** recommends extended care ***confinement*** for a convalescence from a condition which caused that ***hospital confinement,*** or a related condition;

3. The ***covered person*** is under a ***physician's*** continuous care and the ***physician*** certifies that the ***covered person*** must have twenty-four (24) hours-per-day nursing care and completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge.

Covered expenses shall include:

1. ***Room and board*** (including regular daily services, supplies and treatments furnished by the ***extended care facility)*** limited to the ***facility's*** average ***semiprivate*** room rate; and

2. Other services, supplies and treatment ordered by a ***physician*** and furnished by the ***extended care facility*** for ***inpatient*** medical care.

Extended care facility benefits are limited as shown on the *Schedule of Benefits*.

FACILITY PROVIDERS

Covered expenses shall include services of ***facility*** providers if such services would have been covered if performed in a ***hospital*** or ***ambulatory surgical facility.***

HEARING SERVICES OR DEVICES

Covered expenses shall include charges for hearing aid services, supplies and routine hearing exams, except for hearing screenings included in a routine exam (see *Preventive Care),* including external, semi-implantable middle ear, and implantable bone conduction hearing aids, unless specifically provided herein. Benefits shall be limited as specified on the *Schedule of Benefits.*

HOME HEALTH CARE

Home health care enables the ***covered person*** to receive treatment in his home for an ***illness*** or ***injury*** instead of being confined in a ***hospital*** or ***extended care facility.*** The diagnosis, care and treatment must be certified by the attending ***physician*** and must be contained in a ***home health care*** plan which is reviewed and approved by the patient's ***physician*** at least every thirty (30) days.

Covered expenses shall include:

1. Part-time or intermittent nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse in the patient's home;

2. Services provided on an intermittent basis in the patient's home;

3. Medical supplies including drugs and biological;

4. ***Durable medical equipment;***

5. Enteral nutrition/tube feeding when it is the sole source of nutrition, Nursing visits will only be covered for the purpose of instructing the patient and/or caregiver to initiate and terminate the feeding, unless the patient and/or caregiver cannot perform these tasks, in which case, the visits will be subject to the maximum benefit specified on the *Schedule of Benefits.*

6. Home Infusion/Medication Administration Therapy, including:

    - Intravenous, intramuscular, or subcutaneous administration of medication, except for those injectables specifically listed as covered under the *Prescription Drug Program.*
    - Hydration therapy.
    - Blood/blood components.
    - Total parenteral nutrition.
    - Chemotherapy.
    - Intravenous catheter care.
    - Intravenous antibiotic therapy.

    Growth hormone therapy is covered under the Specialty Pharmacy benefit.

A visit by a member of a ***home health care*** team and four (4) hours of ***home health aide service*** will each be considered one (1) ***home health care*** visit. ***Home health*** visits are limited to three (3) per day.

HOSPICE CARE

Hospice care is a health care program providing a coordinated set of services rendered in the patient's or caregiver's home settings for a ***covered person*** suffering from a condition that has a terminal prognosis.

Hospice benefits will be covered only if the ***covered person's*** attending ***physician*** certifies that:

1. The ***covered person*** is terminally ill;

2. The ***covered person*** has a life expectancy of six (6) months or less;

3. A caregiver (family member, friend, or other individual who provides care free of charge) must be available in the home twenty-four (24) hours a day to provide support for the ***covered person's*** daily needs and;

4. The ***covered person*** must meet the requirements of the ***hospice agency.***

Covered expenses shall include:

1. Intermittent services, supplies and treatment provided by a ***hospice*** to a ***covered person*** in a home setting.

2. Respite care, or admission of the patient to an approved facility for up to five (5) days to provide rest for the patient's family or caregiver, limited to once every twenty-one days:

3. Continuous home care, or twenty-four (24) skilled care, provided by a Registered Nurse or Licensed Practical Nurse during a period of crisis, as determined by the ***hospice agency,*** in order to maintain the patient at home, continuous care is generally delivered in four (4) to eight (8) hours blocks and is limited to seventy-two (72) hours per period of crisis; and

4. ***Inpatient*** acute care for pain control or symptom management that cannot be provided in a home setting.

Charges ***incurred*** during periods of remission are not eligible under this provision of the ***Plan.*** Any ***covered expense*** paid under ***hospice*** benefits will not be considered a ***covered expense*** under any other provision of this ***Plan.***

HOSPITAL/AMBULATORY SURGICAL FACILITY

Inpatient hospital admissions and ***outpatient*** surgical procedures are subject to precertification. Failure to obtain precertification will result in a reduction of benefits, refer to *Utilization Review.* ***Covered expenses*** shall include:

1. ***Room and board*** for treatment in a ***hospital,*** including ***intensive care units,*** cardiac care units and similar necessary accommodations. ***Covered expenses*** for ***room and board*** shall be limited to the ***hospital's semiprivate*** rate. ***Covered expenses*** for ***intensive care*** or cardiac care units shall be the ***negotiated rate*** for ***preferred providers*** and the ***customary and reasonable amount*** for ***nonpreferred providers.*** In a ***hospital*** having only private rooms, ***covered expenses*** for ***room and board*** shall be limited to the ***hospital's*** standard private room rate. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the ***covered person.***

2. Miscellaneous ***hospital*** services, supplies, and treatments including, but not limited to:
   - A. Admission fees, and other fees assessed by the ***hospital*** for rendering ***medically necessary*** services, supplies and treatments;
   - B. Use of operating, treatment or delivery rooms;
   - C. Anesthesia, anesthesia supplies and its administration by an employee of the ***hospital;***
   - D. Medical and surgical dressings and supplies, casts and splints;
   - E. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
   - F. Drugs and medicines (except drugs not used or consumed in the ***hospital);***
   - G. X-ray and diagnostic laboratory procedures and services;
   - H. Oxygen and other gas therapy and the administration thereof;
   - I. Therapy services.

3. Services, supplies and treatments described above furnished by an ***ambulatory surgical facility,*** including follow-up care provided within seventy-two (72) hours of a procedure.

4. ***Inpatient*** Extended Active Rehabilitation (EAR) services, up to sixty (60) days per calendar year.

5. Preadmission testing (x-rays and lab tests) performed within seven (7) days prior to a ***hospital*** admission which are related to the condition which is necessitating the ***confinement.*** Such tests shall be payable even if they result in additional medical treatment prior to ***confinement*** or if they show that ***hospital confinement*** is not necessary. Such tests shall not be payable if the same tests are performed again after the ***covered person*** has been admitted.

LONG TERM ACUTE CARE (L.T.A.C.)

Covered expenses shall include specialized acute ***hospital*** care for medically complex patients who are critically ill have multi-system complications and/or failures and require hospitalization on an extended basis in a facility offering specialized treatment programs and an aggressive clinical and therapeutic intervention on a 24/7 basis. When ***medical necessity*** criteria for long term acute care are met, benefits are available for no more than a maximum of three hundred sixty-five (365) days while covered by this ***Plan.*** Deductible and ***coinsurance*** provisions apply for each admission. Beds within a facility may be licensed for different levels of care. Even within the same facility, an admission occurs when the patient is moved from a bed licensed for one level of care to a bed licensed for a different level of care.

MASTECTOMY

Covered expense shall include all services, supplies, and treatment of physical complications from all stages of mastectomy, including lymphedemas.

MEDICAL FOODS

Covered expenses shall include medical food used for treatment of metabolic disorders, included in the newborn screening program, including phenylketonuria (PKU), maple syrup urine disease, homocystinuria, and galactosemia. No benefits are payable for foods for any condition not included in the newborn screening program, including lactose intolerance without a diagnosis. To be eligible for medical food benefits, all of the following criteria must be met:

1. the ***covered person*** must be diagnosed with one (1) of the inherited metabolic disorders;

2. the inherited metabolic disorder must involve amino acid, carbohydrate, or fat metabolism and have medically standard methods of diagnosis, treatment and monitoring, including quantification of metabolites in blood, urine, or spinal fluid or enzyme or DNA confirmation in tissues;

3. the ***covered person*** must require specially processed or treated medical foods generally available only under the supervision of an allopathic or osteopathic ***physician;***

4. the medical foods must be prescribed or ordered under the supervision of allopathic or osteopathic ***physician*** as ***medically necessary*** for the therapeutic treatment of one(1) of the inherited metabolic disorders identified above; and

5. the prescribed or ordered specially processed or treated medical foods must be consumed throughout life, without which, the ***covered person*** may suffer serious mental or physical impairment.

Medical record documentation may be required.

Medical food means modified low protein foods and metabolic formulas that are all of the following:

a. formulated to be consumed or administered through the gastrointestinal tract under the supervision of an allopathic or osteopathic ***physician;***

b. processed or formulated to contain less than one (1) gram of protein per unit of serving (modified low protein foods only);

c. processed or formulated to be defiant in one (1) or more of the nutrients present in typical foodstuffs (metabolic formula only);

d. administered for the medical and nutritional management of a ***covered person*** with limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and

e. essential to the ***covered person's*** optimal growth, health and metabolic homeostasis.

f. Medical foods may be purchased from any source. To receive benefits the ***covered person*** must submit a claim form outlining the following information:
   - the ***covered person's*** name, social security number and group number;
   - the name of the prescribing/ordering ***physician;***
   - the ***covered person*** diagnosis for which the medical foods are prescribed/ordered;
   - where the medical foods were obtained, including the name, address and telephone number of the medical food supplier; and
   - the amount paid for the medical food, including the original or copy of the dated receipt/proof of purchase.

MENTAL AND NERVOUS DISORDERS/CHEMICAL DEPENDENCY

Inpatient

Subject to the precertification provisions of the ***Plan,*** the ***Plan*** will pay the applicable ***coinsurance*** for ***confinement*** in a ***hospital*** or ***treatment center*** for services, supplies and treatment related to the treatment of ***mental and nervous disorders/ chemical dependency.***

Covered expenses shall include:

1. ***Inpatient hospital*** confinement;

2. Individual psychotherapy;

3. Group psychotherapy;

4. Psychological testing;

5. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same ***professional provider.***

Outpatient

The ***Plan*** will pay the applicable ***coinsurance*** for ***outpatient*** services, supplies and treatment related to the treatment of ***mental and nervous disorders*** or ***chemical dependency.***

Office Visit

The ***Plan*** will pay the applicable ***coinsurance*** for office visits related to the treatment of ***mental and nervous disorders*** and ***chemical dependency.*** ***Covered expenses*** shall include: psychotherapy; therapy services for ***chemical dependency***; diagnostic office visits; office visits for monitoring ***mental and nervous disorders;*** electroconvulsive therapy; and counseling for personal, marriage and family problems. Ten (10) hours of psychological and/or neuropsychological testing per calendar year is covered. The treatment of autism is a ***covered expense.***

NEUROPSYCHOLOGICAL AND COGNITIVE TESTING

Covered expenses shall include evaluation of mental function when integral to medical care following head trauma, cerebral vascular accident (stroke), transient ischemic attack (TIA) or other decreased mental function related to a documented medical condition, and/or as part of a ***medically necessary*** evaluation of development delay. After the initial evaluation of developmental delay, regardless of the cause of the delay, the only services which are covered for treatment of that condition are physical therapy, occupational therapy and speech therapy.

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a ***covered expense***. Orthopedic shoes or corrective shoes, that are an integral part of a leg brace shall be covered. Repair or replacement of an orthotic which is ***medically necessary*** due to normal use or physiological change in the patient's condition will be considered a ***covered expense*** and limited to once while covered by this ***Plan.***

PHYSICIAN SERVICES

Covered expenses shall include:

1. Medical treatment, services and supplies including, but not limited to: office visits, ***inpatient*** visits, home visits.

2. Surgical treatment. Separate payment will not be made for ***inpatient*** pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

   If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the ***customary and reasonable amount*** or ***negotiated rate*** that is allowed for the primary procedure; fifty percent (50%) of the ***customary and reasonable amount*** or ***negotiated rate,*** as applicable, will be allowed for each additional procedure performed through the same incision. Any procedure that would be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures.

   If multiple unrelated surgical procedures are performed by two (2) or more surgeons in separate operative fields, benefits will be based on the ***customary and reasonable amount*** or ***negotiated rate,*** as applicable, for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the ***customary and reasonable amount*** or ***negotiated rate,*** as applicable, allowed for that procedure.

3. Surgical assistance provided by a ***physician*** if it is determined that the condition of the ***covered person*** or the type of surgical procedure requires such assistance

4. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant.

5. Consultations requested by the attending ***physician*** during a ***hospital confinement.*** The ***Plan*** will pay for one such consultation per ***illness*** or ***injury.*** Consultations do not include staff consultations which are required by a ***hospital's*** rules and regulations.

6. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

7. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.

8. Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

PODIATRY SERVICES

Covered expenses shall include diagnosis, treatment and prevention of conditions of the feet, including surgical services, incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or débridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.

PREGNANCY

Covered expenses for ***pregnancy*** or ***complications of pregnancy*** shall be provided for a covered female ***employee*** or a covered female ***dependent*** of a covered ***employee.***

In the event of early discharge from a ***hospital*** or ***birthing center*** following delivery, the ***Plan*** will cover two (2) Registered Nurse home visits.

The ***Plan*** shall cover services, supplies and treatments for ***medically necessary*** abortions when the life of the mother would be endangered by continuation of the ***pregnancy*** or when the fetus has a known condition which is incompatible with life.

Complications from an abortion for the covered female ***employee*** or a covered ***dependent*** of an ***employee*** shall be a ***covered expense*** whether or not the abortion is a ***covered expense.***

Group health plans generally may not, under federal law, restrict benefits for any ***hospital*** length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. If delivery occurs in the ***hospital,*** the 48-hour period, or 96-hours, begins at the time of delivery. If delivery occurs outside the ***hospital*** and is later ***confined*** to the ***hospital*** in connection with childbirth, the period begins at the time of the ***hospital*** admission. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law require that a provider obtain authorization from the ***Plan*** for prescribing a length of stay not in excess of the above periods. If a newborn remains hospitalized beyond the time frames specified above, the ***confinement*** must be precertified.

Benefits shall also be paid for expenses ***incurred*** by the natural birth mother for the birth of any child legally adopted by the ***covered person,*** provided that:

a. the child is adopted within one (1) year from the date the legal adoption process began, and

b. the ***covered person*** is legally obligated to pay the costs of birth, and

c. the ***covered person*** has provided notice to the ***Plan administrator*** within sixty (60) days of their acceptability to adopt children.

PRESCRIPTION DRUGS

The ***Plan*** shall cover prescription drugs which are approved for general use by the Food and Drug Administration and dispensed through a ***physician's*** office or as take-home drugs from a ***hospital.*** The ***covered person*** must be charged for such drugs. If eligible for coverage, such drugs shall be covered under this provision of the ***Plan*** and not under the *Prescription Drug Program.* The prescription drug ***copay*** described in the section, *Prescription Drug Program,* shall apply toward the *Medical Expense Benefit, Out-of-Pocket Expense Limit* for ***preferred providers***.

PREVENTIVE CARE

Covered expenses shall include the preventive services as recommended by the U.S. Preventive Services Task Force:

Preventive Screenings: abdominal aortic aneurysm by ultrasonography in men aged sixty-five (65) to seventy-five (75) who have never smoked; mammograms with or without clinical breast examination as follows: one (1) baseline mammogram for women age thirty-five (35) through thirty-nine (39) and one (1) mammogram every ***benefit year*** for women age forty (40) and over; one (1) cervical cancer screening and pelvic examination; cholesterol abnormalities; colorectal cancer beginning at age fifty (50) and continuing until age seventy-five (75); diabetes; depression; screening for hearing loss in newborn infants; osteoporosis; screening for visual acuity in children younger than age five (5); physical check-up; prostate examination and PSA test; and any related diagnostic x-ray and laboratory.

Immunizations: preventive immunizations from birth for all ***covered persons.***

Pediatric: All preventive Pediatric Health Care as recommended by the Bright Futures project.

Well Woman Preventive Services:

For the purpose of this provision, the term "woman" shall mean a female, age-appropriate ***covered person***. ***Covered expenses*** for Well Woman Preventive Services shall include:

1. Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The frequency is annually, however, the ***Plan*** recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs and other risk factors.
2. Screening for gestational diabetes in pregnant women between ages twenty-four (24) and twenty-eight (28) weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk of diabetes.
3. Human papillomavirus testing DNA testing in women with normal cytology result. Screening should begin at thirty (30) years of age and should occur no more frequently than once every three (3) years.
4. Annual counseling on sexually transmitted infections for all sexually active women.
5. Annual counseling and screening for human immune-deficiency virus infection or all sexually active women.
6. All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.
7. In conjunction with each birth, comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
8. Annual screening and counseling for interpersonal and domestic violence.

PROSTHESIS

The purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) shall be a ***covered expense***. A prosthesis ordered prior to the ***covered person's effective date*** of coverage is not covered, even if delivered after the ***effective date*** of coverage. Repair or replacement of a prosthesis which is ***medically necessary*** due to normal use or physiological change in the patient's condition will be considered a ***covered expense*** and limited to once while covered by this ***Plan.***

External, semi-implantable middle ear, and implantable bone conduction hearing aids shall be a ***covered expense.*** Benefits shall not exceed a maximum of twenty-five thousand dollars ($25,000) (combined with any other hearing device) per ***covered person.***

REHABILITATIVE SERVICES

Rehabilitative services must be ordered by a ***physician*** to aid restoration of normal function lost due to ***illness*** or ***injury,*** for congenital anomaly, or for prevention of continued deterioration of function. ***Covered expenses*** shall include services of a ***professional provider*** for physical therapy, speech therapy, or respiratory therapy, subject to the ***maximum benefits*** specified on the *Schedule of Benefits*. ***Covered expense*** does not include recreational programs.

Inpatient

Inpatient rehabilitative services are subject to precertification. ***Inpatient*** rehabilitative services shall also include room and board, including regular daily services and supplies furnished by the ***facility***, ***physician*** and ***professional providers.***

Outpatient

Outpatient rehabilitative services shall also include daily services and supplies furnished by the ***facility, physician*** and ***professional providers.***

SECOND SURGICAL OPINION

Benefits for a second surgical opinion will be payable for ***physician's*** services if an elective surgical procedure (non-emergency surgery) is recommended by the ***physician***. The ***physician*** rendering the second opinion regarding the ***medical necessity*** of such surgery must be a board certified specialist in the treatment of the ***covered person's illness*** or ***injury*** and must not be affiliated in any way with the ***physician*** who will be performing the actual surgery.

In the event of conflicting opinions, a request for a third opinion may be obtained. The ***Plan*** will consider payment for a third opinion the same as a second surgical opinion.

SLEEP DISORDERS

Obstructive Sleep Apnea Syndrome

a. Obstructive sleep apnea syndrome is considered clinically significant with documentation of the following:
   - Apneic-hypopneic index ((AHI)* of fifteen (15) or more, or
   - AHI between five (5) and fourteen (14) with documentation of any of the following associated symptoms:
     - excessive daytime sleepiness
     - history of stroke
     - hypertension
     - impaired cognition
     - insomnia
     - ischemic heart disease
     - mood disorders

   *The AHI is the average number of episodes of apnea and hypopnea per hour as recorded by a polysomnography based on a minimum of two (2) hours actual sleep. The polysomnography must be performed by a certified sleep laboratory, either in an overnight laboratory or home setting, and reviewed by a certified practitioner and ***professional provider.***

b. The following treatments for clinically significant obstructive sleep apnea syndrome are considered ***medically necessary***:
   - Continuous positive airway pressure (CPAP) for an adult
   - Oral appliance with document of the following:
     - Polysomnography indicates five (5) or more episodes of apnea per hour during sleep, and
     - Obstructive sleep apnea is not of central nervous system (CNS) origin
   - Uvulopalatopharyngoplasty (UPPP) for an individual who has not responded to or cannot tolerate the use of a CPAP device
   - Hyoid suspension, maxillofacial surgery, including mandibular-maxillary advancement or surgical modification of the tongue with documentation of the following:
     - Objective hypopharyngeal obstruction, and
     - Individual has not responded to or cannot tolerate the use of a CPAP device.

c. The following treatments for obstructive sleep apnea syndrome are considered ***investigational*** based upon insufficient scientific evidence to permit conclusion concerning the effect on health outcomes and insufficient evidence to support improvement of the net health outcome:

- Laser-assisted uvulopalatoplasty (LAUP)
- Somnoplasty

Upper Airway Resistance Syndrome

a. Upper airway resistance syndrome is considered clinically significant with documentation of ten (10) episodes of EEG arousal per hour of sleep in association with negative intrathoracic pressures. The following treatments for clinically significant upper airway resistance syndrome are considered ***medically necessary:***
   - Continuous positive airway pressure (CPAP) for an adult
   - Uvlopalaropharyngoplasty (UPPP) for an individual who has not responded to or cannot tolerate the use of a CPAP device.

b. The following treatments for upper airway resistance syndrome are considered ***investigational*** based upon insufficient scientific evidence to permit conclusion concerning the effect on health outcomes and insufficient evidence to support improvement of the net health outcome:
   - Laser-assisted uvulopalatoplasty (LAUP)
   - Somnoplasty

SPECIAL EQUIPMENT AND SUPPLIES

Covered expenses shall include ***medically necessary*** special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; disposable supplies required to operate or maintain a covered prosthesis or ***durable medical equipment;*** catheters; allergy serums; crutches; electronic pacemakers; oxygen and the administration thereof, including rental charges for thirty-six (36) months. Beginning six (6) months after the thirty-six (36) month rental period ends, maintenance visits are covered every six (6) months for two (2) years at which time the concentrator will be deemed to have met its reasonable lifetime use and the billing cycle will start again if the patient still needs oxygen; intravenous injections and solutions and their administration; the purchase of one (1) wig per calendar year for the diagnosis of alopecia resulting from ***illness*** *or* ***injury;*** blood and blood components and derivatives that are not donated or replaced; the initial pair of eyeglasses or contact lenses due to cataract surgery subject to the ***maximum benefit*** specified on the *Schedule of Benefits* and prescribed within six (6) months following surgery; soft lenses or sclera shells intended for use in the treatment of ***illness*** or ***injury*** of the eye; surgical dressings and other medical supplies ordered by a ***professional provider*** in connection with medical treatment, but not common first aid supplies.

STERILIZATION

Covered expenses shall include elective sterilization procedures for the covered ***employee*** or covered spouse. Reversal of sterilization is not a ***covered expense.***

TEMPOROMANDIBULAR JOINT DYSFUNCTION

Surgical and nonsurgical treatment of temporomandibular joint (TMJ), myofacial pain syndrome or non-surgical orthognathic treatment shall be a ***covered expense,*** but shall not include orthodontia or prosthetic devices prescribed by a ***physician*** or ***dentist***. The ***maximum benefit*** payable for diagnosis and treatment of TMJ, myofacial pain syndrome or orthognathic disorders per ***covered person*** is shown in the *Schedule of Benefits.* This limitation shall apply whether treatment is provided by a ***hospital, physician, dentist,*** physical therapist or oral surgeon.

THERAPY SERVICES

Covered expenses shall include the ***facility*** and services of a ***professional provider*** for x-ray, radium or radiotherapy treatment; chemotherapy; dialysis therapy or treatment; and IV infusion therapy, whether rendered on an ***inpatient*** or ***outpatient*** basis. The services of technicians are included. Chemotherapy and infusions must be precertified, regardless of the place of service. Failure to obtain precertification shall result in a reduction in benefits.

TRANSPLANT

Services, supplies and treatments in connection with the listed human-to-human organ and tissue transplant procedures will be considered ***covered expenses*** subject to the following conditions:

1. When the recipient is covered under this ***Plan,*** the ***Plan*** will pay the recipient's ***covered expenses*** related to the transplant.

2. When both the donor and recipient are covered under this ***Plan,*** the ***Plan*** will pay the donor's ***covered expenses*** related to the transplant, will be processed under the recipient's benefit.

3. Expenses ***incurred*** by the donor who is not ordinarily covered under this ***Plan*** according to *Eligibility* requirements will be ***covered expenses*** to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, within six (6) months following the transplant and provided the recipient is covered under this ***Plan.***

4. Surgical, storage and transportation costs directly related to procurement and transplant of an organ or tissue used in transplant procedure will be covered for each procedure completed if the donor or recipient lives more than seventy-five (75) from the transplant site. Such charges do not count for the initial transplant evaluation but will count charges for treatment of complications or for routine transplant follow-up. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a ***covered expense*** under this ***Plan.***

5. Marrow search and procurement when the ***covered person*** is the recipient of a covered allogenic transplant.

6. Air and ground transportation of a medical team to and from the transplant site in the U.S. for the procurement of an organ or tissue that is subsequently transplanted.

If a ***covered person's*** transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement as described above.

The following are covered transplant procedures:

1. Organ transplants, including heart, heart/lung (lobar, single and double lung), kidney, pancreas, kidney/pancreas and liver.

2. Small bowel, small bowel-multivisceral.

3. Corneal transplants.

4. Autologous islet transplantation (AECT).

5. Allogenic, autologous and/or syngenic bone marrow transplants.

Benefits for allogenic, autologous and/or syngenic bone marrow transplants (including peripheral stem cell rescue (PSCR) procedures and/or HDC or HDR are not available for treatment of all conditions or all stages of a condition, even is a provider recommends such treatment.

WELL NEWBORN CARE

The ***Plan*** shall cover well newborn care (including circumcision) while the mother is confined for delivery. ***Covered expenses*** for services, supplies or treatment of the newborn child shall be considered charges of the child and as such, subject to a separate deductible (if applicable), ***copay*** and ***coinsurance*** from the mother.

MEDICAL EXCLUSIONS

In addition to *Plan Exclusions*, no benefit will be provided under this ***Plan*** for medical expenses for the following:

1. Charges for services, supplies or treatment for the reversal of sterilization procedures.

2. Charges for services, supplies or treatment related to the diagnosis or treatment of infertility and artificial reproductive procedures, including, but not limited to: artificial insemination, invitro fertilization, surrogate mother, fertility drugs when used for treatment of infertility, embryo implantation, or gamete intrafallopian transfer (GIFT).

3. Charges for services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

4. Charges for treatment or surgery for sexual dysfunction.

5. Charges for ***hospital*** admission on Friday, Saturday or Sunday unless the admission is an ***emergency*** situation, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, ***hospital*** expenses will be payable commencing on the date of actual surgery.

6. Charges for ***inpatient room and board*** in connection with a ***hospital confinement*** primarily for diagnostic tests or therapy, unless it is determined by the ***Plan*** that ***inpatient*** care is ***medically necessary.***

7. Charges for biofeedback therapy.

8. Charges for services, supplies or treatments which are primarily educational in nature, except as specified in *Medical Expense Benefit, Patient Education and Preventive Care;* charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.

9. Except as specifically stated in *Medical Expense Benefit, Dental Services*, charges for or in connection with: treatment of ***injury*** or disease of the teeth; oral surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants.

10. Except as specified in *Preventive Care,* charges for routine vision examinations and eye refractions; orthoptics; eyeglasses or contact lenses, except as specifically stated under *Special Equipment and Supplies*; dispensing optician's services.

11. Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such surgery.

12. Except as ***medically necessary*** for the treatment of diabetes, neurological involvement or peripheral-vascular ***illness,*** charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.

13. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a ***physician,*** such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-hospital adjustable beds, exercise equipment or other items considered "luxury medical equipment", such as, motorized wheelchairs or other vehicles, bionic or computerized artificial limbs

14. Except as mandated by Healthcare Reform, charges for nonprescription drugs, such as vitamins (except prenatal vitamins), cosmetic dietary aids, and nutritional supplements, except as specified herein.

15. Expenses for a ***cosmetic surgery*** or ***cosmetic treatment*** and all related services, except as specifically stated in *Medical Expense Benefit, Cosmetic Surgery.*

16. Charges ***incurred*** as a result of, or in connection with, ***cosmetic surgery*** or any procedure or treatment excluded by this ***Plan*** which has resulted in medical complications, except for complications from a non-covered abortion.

17. Charges for services provided to a ***covered person*** for an elective abortion. However, complications from such procedure shall be a ***covered expense.*** Refer to *Medical Expense Benefit, Pregnancy* for ***Plan's*** coverage of non-elective abortions.

18. Except as specified in *Preventive Care,* charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of a treatment plan for another ***illness;*** however, ***medically necessary*** charges for bariatric surgery, as specified in *Bariatric Surgery* will be covered.

19. Except a specified in *Preventive Care,* a charge for services, supplies and treatment for smoking cessation programs, or related to the treatment of nicotine addiction, including smoking deterrent patches.

20. Except as specified in *Preventive Care* or *Hearing Services or Device ,* charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid; or charges for a cochlear implant.

21. Charges related to acupuncture or acupressure treatment.

22. Charges for ***custodial care,*** domiciliary care or rest cures.

23. Charges for travel, meals or accommodations, whether or not recommended by a ***physician,*** except as specifically provided herein.

24. Except as specified in *Special Equipment and Supplies,* charges for wigs, artificial hair pieces, artificial hair transplants, or any drug - prescription or otherwise -used to eliminate baldness or promote hair growth.

25. Charges for expenses related to hypnosis.

26. Charges for prescription drugs that are covered under the *Prescription Drug Program.*

27. Charges for any services, supplies or treatment not specifically provided herein.

28. Charges for professional services billed by a ***physician*** or Registered Nurse, Licensed Practical Nurse or Licensed Vocational Nurse who is an employee of a ***hospital*** or any other ***facility*** and who is paid by the ***hospital*** or other ***facility*** for the service provided.

29. Charges for environmental change including ***hospitalization*** or ***physician*** charges connected with prescribing an environmental change.

30. Charges for ***room and board*** in a ***facility*** for days on which the ***covered person*** is permitted to leave (a weekend pass, for example.)

31. Charges for replacement braces of the leg, arm, back, neck or artificial arms or legs, unless there is sufficient change in the ***covered person's*** physical condition to make the original device no longer functional.

32. Charges for activity therapy, milieu therapy or any care primarily intended to assist an individual in the activities of daily living or for the comfort or convenience of the patient or family member except for limited ***hospice*** benefits as specified herein.

33. Charges for non-traditional or alternative medical therapies, e.g. interventions, services or procedures not commonly accepted as part of allogenic or osteopathic practices, naturopathic and homeopathic medicine, diet therapies, nutritional or lifestyle therapies and aromatherapy.

34. Charges for a ***covered person*** receiving Botox therapy, regardless of ***medical necessity*** and/or recommendation by a ***professional provider*** for any of the following reasons:
    a. Headache, including cerviogenic, cluster, migraine or tension headache; or
    b. Fibromyositis; or
    c. Painful cramps; or
    d. Anal sphincter dysfunction; or
    e. Lower urinary tract dysfunction (e.g. detrusor overactivity/overactive bladed and detrusor-sphincter dyssynergia); or
    f. Bell's palsy; or
    g. Stuttering; or
    h. Irritable colon; or
    i. Biliary dyskinesia; or
    j. Temporomandibular joint disorders; or
    k. Chronic low back pain; or
    l. Chronic neck pain; or
    m. Gastroparesis; or
    n. Clubfoot; or
    o. Cranial/facial pain of unknown etiology; or
    p. Piriformis syndrome; or
    q. Pylorospasm; or
    r. Chronic constipation; or
    s. Wrinkles, frown lines; or
    t. Aging neck; or
    u. Blepharoplasty (eye lids).

35. Charges for services related to improving cognitive functioning (i.e. higher brain functions), reinforcing or re-establishing previously learned thought processes, compensary training, sensory integrative activities, or services related to employability.

36. Charges for complications of body piercing, implants (body art) and/or tattooing, e.g. the evaluation, treatment, removal, and/or lacerations, infections, cellulites and keloids.

37. Charges for counseling in the absence of ***illness*** or ***injury,*** including, but not limited to, marital, education, social, behavior modification services, or recreational therapy; or counseling with the patient's friends, employer, school counselor or school teacher.

38. Charges for court-ordered testing, treatment or therapy, unless such services are otherwise covered under this ***Plan.***

39. Charges for all dietary, caloric and nutritional supplements, e.g. specialized formulas for infants, children or adults or other special foods or diets, even if prescribed by a ***professional provider,*** except as specified in *Medical Foods.*

40. Charges for repair costs that exceed the replacement cost of an item; repair or replacement costs that are lost or damaged due to neglect or use not recommended by the manufacturer; medical equipment and/or supplies that can be purchased over the counter; items primarily for personal comfort, convenience or assistance in daily living; supplies used by a provider during office treatments; artificial organs determined to be ***experimental/investigational.***

41. Charges for services related to a surrogate ***pregnancy.***

42. No benefits are payable for medical foods for the following: foods for any conditions other than those inherited metabolic disorders as specified in *Medical Foods;* natural foods that are naturally low in protein and/or glactose; spices or flavorings; foods/flavorings available to any person, even those without inherited metabolic disorders that may be purchased without a prescription or that do not require supervision by an allopathic or osteopathic provider.

43. Charges for prescription medications and over-the-counters, including pharmaceutical manufacturer's samples, dispensed to the patient in the office by any mode of administration. This does not include eligible injectable drugs administered in the provider's office. Such eligible drugs must be obtained through the Specialty Pharmacy Program.

44. Charges for ***outpatient*** therapy, ***outpatient*** cardiac rehabilitation and ***inpatient*** extended active rehabilitation for these items: cognitive therapy; services rendered after a patient has met functional goals and no objectively measurement improvement is reasonably expected, custodial therapy, massage therapy or computer speech training/therapy programs or devices.

45. Charges for routine care or services not directly related to an ***illness*** or ***injury,*** except as specified in *Preventive Care.*

46. Charges for screening and/or diagnostic testing or treatment without a personal history of a specific diagnosis, except as specified in *Preventive Care.*

47. Charges for high-dose chemotherapy, high dose radiation or other services administered with a non-covered transplant.

48. Charges for transportation or travel expenses, except as specified

PRESCRIPTION DRUG PROGRAM

The ***employer*** has contracted with a nationwide network of ***participating pharmacies*** to provide prescription drugs and medicines at a reduced rate to ***covered persons. Covered expenses,*** limitations and exclusions for prescription drugs are determined through the referenced contract. The Prescription Drug Program described herein is a separate benefit from the Medical Expense Benefit of the ***Plan.*** However, benefits of the Prescription Drug Program are subject to the ***maximum benefit*** while covered by this ***Plan*** as shown on the *Schedule of Benefits, Medical Benefits.*

The prescription drug ***copays*** will apply to the *Medical Expense Benefit* ***preferred provider*** out-of-pocket expense limit. Once the ***benefit year preferred provider*** out-of-pocket expense limit has been reached, the ***Plan*** will pay for ***covered persons*** covered prescription drugs at 100% for the remainder of the ***benefit year.***

There are two (2) aspects of the Prescription Drug Program.

PHARMACY OPTION

Participating pharmacies have contracted with the ***Plan*** to charge ***covered persons*** reduced fees for covered prescription drugs.

The ***copay*** is applied to each covered pharmacy drug and is shown on the S*chedule of Benefits*. Any one prescription is limited to a thirty (30) day supply.

If a drug is purchased from a ***nonparticipating pharmacy*** or a ***participating pharmacy*** when the ***covered person's*** ID card is not used, the ***covered person*** must pay the entire cost of the prescription. No benefits are payable under this ***Plan.***

MAIL ORDER OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer ***covered persons*** significant savings on prescriptions.

The ***copay*** is applied to each covered mail order prescription charge and is shown on the *Schedule of Benefits.* Any one prescription is limited to a ninety (90) day supply.

PRIOR AUTHORIZATION

Certain categories of medication require prior authorization from the Pharmacy Benefit Manager. These categories include, but are not limited to:

1. Acne Medication – Acne medications with Tretionin agents are covered for those under age twenty-four then require prior authorization.

2. Anti-Fungual.

3. Migraine Medications.

4. Certain Injectable Drugs.

COVERED PRESCRIPTION DRUGS

1. All drugs prescribed by a ***physician*** that require a prescription either by federal or state law, except insulin and drugs excluded by the ***Plan.***

2. All compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.

3. Diabetic supplies when prescribed by a ***physician.***

4. Contraceptives.

5. Over-the counter medications as mandated by Healthcare Reform.

For a complete listing of covered prescription drugs, refer to the Pharmacy Benefit Management contract.

LIMITS TO THIS BENEFIT

This benefit applies only when a ***covered person incurs*** a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a ***physician.***

2. Refills up to one year from the date of order by a ***physician.***

PRESCRIPTION EXCLUSIONS

In addition to the *Plan Exclusions,* no prescription benefit shall be payable for the following:

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin, or over the counter medications which can be purchased as specifically stated herein.

2. Devices of any type, even though such devices may require a prescription. These include, but are not limited to: therapeutic devices, artificial appliances, glucose monitors, braces, support garments, or any similar device.

3. Immunization agents or biological sera.

4. A drug or medicine labeled: “Caution - limited by federal law to investigational use.”

5. Experimental drugs and medicines, even though a charge is made to the ***covered person*** including DESI drugs (drugs determined by the FDA as lacking substantial evidence of effectiveness.)

6. Any charge for the administration of a covered prescription drug.

7. Any drug or medicine that is consumed or administered at the place where it is dispensed, except as mandated by Healthcare Reform.

8. A drug or medicine that is to be taken by the ***covered person***, in whole or in part, while ***hospital confined.*** This includes being confined in any institution that has a facility for dispensing drugs.

9. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.

10. A charge for fertility or infertility medication.

11. A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or diabetic supplies. Certain medical foods are covered under the *Medical Expense Benefit.*

12. A charge for any drug not approved by the Food and Drug Administration (FDA).

13. A charge for impotence medications or to treat sexual dysfunction.

14. A charge for performance, athletic performance or lifestyle enhancement drugs or supplies).

15. A charge for prescriptions or refills for drugs that are lost, stolen, spilled, spoiled or damaged,

16. A charge for drug delivery implants.

17. A charge for any prescription drug dispensed in unit-dose packaging unless that is the only form in which the drug is available.

For a complete listing of prescription exclusions, refer to the Pharmacy Benefit Management contract.

PLAN EXCLUSIONS

The ***Plan*** will not provide benefits for any of the items listed in this section, regardless of ***medical necessity*** or recommendation of a ***physician*** or ***professional provider.***

1. Charges for services, supplies or treatment from any ***hospital*** owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.

2. Charges for an ***injury*** sustained or ***illness*** contracted while on active duty in military service, unless payment is legally required.

3. Charges for services, supplies or treatment for treatment of ***illness*** or ***injury*** which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.

4. Any condition for which benefits of any nature are recovered or are found to be recoverable, either by adjudication or settlement, under any Workers' Compensation law, Employer's liability law, or occupational disease law, even though the ***covered person*** fails to claim rights to such benefits or fails to enroll or purchase such coverage.

5. Charges in connection with any ***illness*** or ***injury*** arising out of or in the course of any employment intended for wage or profit, including self-employment.

6. Charges made for services, supplies and treatment which are not ***medically necessary*** for the treatment of ***illness*** or ***injury,*** or which are not recommended and approved by the attending ***physician,*** except as specifically stated herein, or to the extent that the charges exceed the ***customary and reasonable amount,*** exceed the ***negotiated rate*** or ***Medicare*** – like rate, as applicable.

7. Charges in connection with any ***illness*** or ***injury*** of the ***covered person*** resulting from or occurring during the ***covered person's*** commission or attempted commission of a criminal battery or felony. Claims shall be denied if the ***Plan administrator*** has reason to believe, based on objective evidence such as police reports or medical records, that a criminal battery or felony was committed by the ***covered person.***

8. To the extent that payment under this ***Plan*** is prohibited by any law of any jurisdiction in which the ***covered person*** resides at the time the expense is ***incurred.***

9. Charges for services rendered and/or supplies received prior to the ***effective date*** or after the termination date of a person's coverage.

10. Any services, supplies or treatment for which the ***covered person*** is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.

11. Charges for services, supplies or treatment that is considered ***experimental/investigational,*** except as specified herein***.***

12. Charges for services, supplies or treatment rendered by any individual who is a ***close relative*** of the ***covered person*** or who resides in the same household as the ***covered person.***

13. Charges for services, supplies or treatment rendered by physicians or ***professional providers*** beyond the scope of their license; for any treatment, ***confinement*** or service which is not recommended by or performed by an appropriate ***professional provider.***

14. Charges for ***illnesses*** or ***injuries*** suffered by a ***covered person*** due to the action or inaction of any party if the ***covered person*** fails to provide information as specified in *Subrogation/Reimbursement.*

15. Claims not submitted within the ***Plan's*** filing limit deadlines as specified in *Claim Filing Procedures.*

16. Charges for e-mail, internet or telephone consultations, completion of claim forms, charges associated with missed appointments.

17. Charges for services, supplies or treatment for ***covered persons*** who are Native American which are rendered by Indian Health Services or Contract Health Services, or for any charges for services, supplies, or treatment rendered by any other health care provider wherein Indian Health Services/Contract Health Services made a referral for such.

18. Charges for services, supplies, care or treatment to a ***covered person*** for an ***injury*** which occurred as a result of that ***covered person's*** illegal use of alcohol. Claims shall be denied if the ***Plan administrator*** has reason to believe, based on objective evidence such as police reports or medical records of the ***covered person's*** illegal use of alcohol. Expenses will be covered for injured ***covered persons*** other than the person illegally using alcohol and expenses will be covered for ***chemical dependency*** treatment as specified on the *Schedule of Benefits*. This exclusion does not apply if the ***injury*** resulted from an act of domestic violence or an underlying medical condition.

19. Charges for services, supplies, care or treatment to a ***covered person*** for ***injury*** resulting from that ***covered persons*** voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a ***physician.*** Expenses will be covered for injured ***covered persons*** other than the person using controlled substances and expenses will be covered for ***chemical dependency*** as specified herein.

20. Charges for care and treatment of an ***injury*** or ***illness*** that results from activity where the ***covered person*** is found by a court of competent jurisdiction and/or a jury of his/her peers to have been negligent in his/her actions, as "negligence" is defined by the jurisdiction where the activity occurred.

21. Charges ***incurred*** outside the United States if the ***covered person*** traveled to such a location for the sole purpose of obtaining services, supplies or treatment.

ELIGIBILITY

This section identifies the ***Plan's*** requirements for a person to be eligible to enroll for coverage under this ***Plan.*** Refer to the sections entitled, *Enrollment,* and *Effective Date of Coverage* for more information about the ***Plan's*** requirements for coverage hereunder.

The ***employer*** engages the use of ***measurement periods*** for tracking an ***employee's hours of service.*** If during a ***measurement period,*** the ***employee*** averages thirty (30) ***hours of service*** per ***week,*** the ***employee*** will be deemed eligible to enroll for coverage under this ***Plan*** as a ***full-time, regular employee.*** For the purpose of the following provisions on ***employee*** eligibility under the terms of the ***Plan,*** whether an ***employee*** averages thirty (30) ***hours of service*** per ***week*** will be determined in accordance with the policies and procedures adopted by the ***employer*** which are determined in a manner consistent with the Internal Revenue Code Section 4980H and the regulations issued thereunder.

The ***employer*** has the option of engaging a "Monthly***" measurement period*** for some ***employee*** classifications, and the "Look Back" ***measurement period*** for other ***employee*** classifications:

1. The "Monthly" ***measurement period*** is for those ***employees*** who are reasonably determined at the time of hire to be a ***full-time, regular employee.***

2. The "Look Back" ***measurement period*** is for those ***employees*** whose ***hours of service*** cannot be categorized as ***full-time, regular*** and are generally placed in the "Look Back" ***measurement period*** method***.*** The Look Back ***measurement period*** method consists of three components:

   A. A ***measurement period*** shall be for the purpose of tracking an ***employee's hours of service*** during the ***measurement period;***

   B. The ***administrative period*** shall be for the purpose of assessing an ***employee's*** eligibility for coverage under the ***Plan,*** prepare and distribute enrollment materials, and allow time for ***employee*** submission of properly completed application for enrollment by the end of the ***administrative period.***

   C. The ***stability period*** shall be for the purpose of establishing the period of time the eligible, enrolled ***employee*** shall remain on the ***Plan*** if the ***employee*** met the eligibility criteria during the ***measurement period***, subject to any ***break in service***, and *Termination of Coverage* provisions of the ***Plan.***

   After the ***initial measurement period***, the ***stability period*** and the ***standard measurement period*** overlap on the time line.

EMPLOYEE ELIGIBILITY

NEW HIRES

For Full-time, Regular Employees on the Monthly Measurement or Look Back Measurement Period Method:

All ***full-time*** or ***part-time employees*** working at least thirty (30) hours per week shall be eligible to enroll for coverage under this ***Plan.*** This does not include temporary ***employees.***

For Qualifying Part-time Employees on the Look Back Measurement Period Method:

Any other ***employees,*** including, but not limited to, ***seasonal employees***, who are not ***full-time, regular employees*** to the extent that such ***employees*** average thirty (30) ***hours of service*** per ***week*** over the ***employee's*** applicable ***initial***

measurement period, shall be eligible to enroll for coverage under this ***Plan*** during the applicable ***administrative period.***

If a ***qualifying part-time employee*** transfers to a ***full-time, regular employee*** position prior to the start of the ***qualifying part-time employee's new employee stability period,*** the ***employee*** will become eligible for coverage as a ***full-time, regular employee.***

FOR ONGOING EMPLOYEES ON THE LOOK BACK MEASUREMENT PERIOD METHOD

Once an ***employee*** has completed the ***standard measurement period,*** eligibility will be based solely on the ***employee's hours of service*** during the ***standard measurement period.*** Any ***employee*** who averages thirty (30) ***hours of service*** per ***week*** during the ***standard measurement period (ongoing employees)*** will be eligible for coverage under the ***Plan*** during the next ***ongoing employee stability period*** to the extent that the ***ongoing employee*** remains employed, subject to the ***Plan's break in service*** rules, and *Termination of Coverage* provisions of the ***Plan.***

BREAK IN SERVICE RULES

1. If the ***employee*** experiences a ***break in service*** during a ***measurement period*** and then again resumes ***hours of service,*** such ***employee*** will be treated as a New Hire ***employee*** upon the date that the ***employee*** resumes ***hours of service*** for the ***employer.***

2. If during an ***ongoing employee stability period,*** the ***employee*** experiences a period without any ***hours of service,*** and subsequently resumes ***hours of service*** but does not experience a ***break in service***, the ***employee*** will be treated as a continuous ***employee.*** Such an ***employee*** will be eligible for coverage under the ***Plan*** upon return to work if they were enrolled in coverage prior to the start of the period with no ***hours of service***.

   Such coverage will be effective on the first day of month that coincides with or follows the date the ***employee*** resumes ***hours of service,*** provided the ***employee*** submits the completed application for enrollment to the ***employer*** within thirty (30) days of resuming ***full-time*** status.

   Prior benefit accumulators shall apply as though there was no break in coverage for any ***employee*** that experiences a ***break in service*** and then returns to coverage under the ***Plan.***

3. Impact of ***special unpaid leaves of absence***: If the ***employee*** takes a ***special unpaid leave of absence*** during a ***measurement period***, the ***employer*** will disregard all consecutive ***weeks*** of such unpaid leave when determining the average ***hours of service*** during the applicable ***measurement period.***

ADDITIONAL TERMS OF ELIGIBILITY FOR QUALIFYING PART-TIME EMPLOYEES AND ONGOING EMPLOYEES ON THE LOOK BACK MEASUREMENT PERIOD METHOD

The ***employer*** will determine a ***qualifying part-time employee's*** and an ***ongoing employee's*** eligibility for coverage under the ***Plan*** in accordance with the following requirements:

1. An ***employee's hours of service*** during the applicable ***measurement period*** will be considered in determining eligibility for coverage under the ***Plan*** to the extent not preceded by a ***break in service.***

2. Impact on Payroll Periods: For payroll periods that are one ***week***, two ***weeks,*** or semi-monthly in duration, the ***employer*** is permitted to treat as a ***measurement period*** a period that ends on the last day of the payroll period preceding the payroll period that includes the date that would otherwise be the last day of the ***measurement period***, provided that the ***measurement period*** begins on the first day of the payroll period that includes the date that would otherwise be the first day of the ***measurement period***.

   The ***employer*** may also treat as a ***measurement period,*** a period that begins on the first day of the payroll period that follows the payroll period that includes the date that would otherwise be the first day of the ***measurement period,*** provided that the ***measurement period*** ends on the last day of the payroll period that includes the date that would otherwise be the last day of the ***measurement period***.

DEPENDENT(S) ELIGIBILITY

The following describes ***dependent*** eligibility requirements. The ***employer*** will require proof of ***dependent*** status.

1. The term "spouse" means the spouse of the ***employee*** under a legally valid existing marriage in the state in which the ***employee*** resides, unless court ordered separation exists. The term spouse does not include an ***employee's*** domestic partner or common-law spouse.

2. The term "child" means the ***employee's*** natural child, stepchild, legally adopted child, foster child that is placed with the ***employee*** by an authorized agency or court of law, and a child for whom the ***employee*** has been appointed legal guardian, either temporary or permanent, prior to age eighteen (18) by a court of law, provided the child has not reached the end of the month of his or her twenty-sixth (26th) birthday.

3. An eligible child shall also include any other child of an ***employee*** or their spouse who is recognized in a qualified medical child support order (QMCSO), which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan,*** even if the child is not residing in the ***employee's*** household. Such child shall be referred to as an ***alternate recipient***. ***Alternate recipients*** are eligible for coverage regardless of whether the ***employee*** elects coverage for himself. An application for enrollment must be submitted to the ***employer*** for coverage under this ***Plan.*** The ***employer/Plan administrator*** shall establish written procedures for determining whether a medical child support order is a QMCSO and for administering the provision of benefits under the ***Plan*** pursuant to a valid QMCSO. The ***employer/Plan administrator*** reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency. ***Employees*** and ***dependents*** may obtain, without charge, a copy of the ***employer's*** procedures governing qualified medical child support orders (QMCSO).

4. Adopted children, who are less than eighteen (18) years of age at the time of adoption, shall be considered eligible from the date the child is ***placed for adoption.*** ***"Placed for adoption"*** means the date the ***employee*** assumes legal obligation for the total or partial financial support of the child during the adoption process.

5. A child who is unmarried, incapable of self-sustaining employment, and dependent upon the ***employee*** for support due to a mental and/or physical disability, and who was covered under the ***Plan*** prior to reaching the maximum age limit or other loss of ***dependent's*** eligibility, will remain eligible for coverage under this ***Plan*** beyond the date coverage would otherwise be lost.

   Proof of incapacitation must be provided within thirty (30) days of the child's loss of eligibility and thereafter as requested by the ***employer*** or ***claims processor,*** but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:

   A. Cessation of the mental and/or physical disability;

   B. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Eligible ***dependents*** do not include:

1. Other individuals living in the covered ***employee's*** home, but who are not eligible as defined.

2. The legally divorced former spouse of the ***employee.***

3. Any person who is considered a domestic spouse or common-law spouse.

4. Any person who is on active duty in any military service of any country, unless otherwise specified herein.

5. Any person who is covered under the ***Plan*** as an ***employee***

ENROLLMENT

The benefits of this ***Plan*** are based on a ***benefit year.*** If an ***employee*** or ***dependent*** enrolls for coverage at any time during the ***benefit year,*** the benefits will be calculated on a ***benefit year.***

APPLICATION FOR ENROLLMENT

NEW HIRES

Full-time, Regular Employee on the Monthly Measurement or Look Back Measurement Period Method

A ***full-time, regular employee*** must file a written application with the ***employer*** for coverage hereunder for himself and his eligible ***dependents*** within thirty (30) days of the date coverage would otherwise be effective. Refer to the section entitled, *Effective Date of Coverage.* The ***employee*** shall have the responsibility of timely forwarding to the ***employer*** all applications for enrollment hereunder.

Qualifying Part-time Employee on the Look Back Measurement Period Method

An ***employee*** who has completed the ***initial measurement period*** and during the ***administrative period***, the ***employer*** deems the ***employee*** to have met the eligibility requirements of the ***Plan***, the ***qualifying part-time employee*** must file a written application with the ***employer*** for coverage hereunder for himself and his eligible ***dependents*** during the ***administrative period.*** The ***employee*** shall have the responsibility of timely forwarding to the ***employer*** all applications for enrollment hereunder prior to the end of the ***administrative period.***

FOR ONGOING EMPLOYEES ON THE LOOK BACK MEASUREMENT PERIOD METHOD

Ongoing employees who have completed their ***standard measurement period*** and during the ***administrative period,*** the ***employer*** deems the ***employee*** to have met the eligibility requirements of the ***Plan,*** may elect coverage for himself and any eligible ***dependents*** if he is not covered under the ***Plan,*** or may change benefit plan options for himself or any enrolled ***dependents*** during the ***administrative period***. Enrolled ***employees*** may add or drop coverage for themselves or for enrolled ***dependents*** during the ***administrative period.*** The ***employee*** shall have the responsibility of timely forwarding to the ***employer*** all applications for enrollment hereunder prior to the end of the ***administrative period.***

EMPLOYEE RESPONSIBILITY FOR ENROLLMENT

Employees deemed eligible to enroll for coverage under this ***Plan*** shall bear the responsibility of submitting a properly completed application for enrollment to the ***employer*** within the timeline as determined by the ***Plan.*** The ***employee*** shall have the responsibility of timely forwarding to the ***employer*** all applications for enrollment hereunder.

If the ***employee*** acquires a ***dependent*** after submitting the application for enrollment to the ***employer*** and wishes to enroll the eligible ***dependents,*** the ***employee*** shall submit a revised application for enrollment to the ***employer*** within thirty (30) days of marriage, or the acquiring of children, or birth of a child. The ***employer*** must be notified of any change in a ***dependent's*** loss of eligibility within thirty (30) days of the change***,*** including divorce or legal separation, death, child's reaching the maximum age for eligibility under this ***Plan.*** Forms are available from the ***employer*** for reporting changes in ***dependents'*** eligibility as required.

Once a properly completed application for enrollment has been submitted to the ***employer*** and coverage has become effective, as defined in the section entitled, *Effective Date of Coverage,* the ***employee's*** enrollment option shall remain in effect. The only opportunity to change the enrollment option shall be during the ***administrative period*** for those ***employees*** under the look back ***measurement period*** method; or during the open enrollment for those ***employees*** under the monthly ***measurement period*** method***;*** or upon a Special Enrollment option as defined below. A written waiver of

coverage stating the existence of coverage under another ***creditable coverage*** must have been completed by the ***employee*** in order for the ***employee*** to be considered a Special Enrollee at a later date.

Failure to complete the application for enrollment within thirty (30) days shall result in the *Late Enrollment* provision applying to the individual. An ***alternate recipient*** can be enrolled in the ***Plan*** at any time and shall not be subject to the *Late Enrollment* provision.

EMPLOYEE/SPOUSE ENROLLMENT

Every eligible ***employee*** may enroll eligible ***dependents.*** However, if both the husband and wife are ***employees,*** each individual will be covered as an ***employee.*** An ***employee*** cannot be covered as an ***employee*** and a ***dependent.*** Eligible children may be enrolled as ***dependents*** of one spouse, but not both.

TRANSFER OF COVERAGE

If a husband and wife are both ***employees*** and are covered as ***employees*** under this ***Plan*** and one of them terminates, the terminating spouse and any of the eligible, enrolled children will be permitted to immediately enroll under the remaining ***employee's*** coverage. Such new enrollment will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the ***employee*** or the ***dependent*** of the terminated ***employee.***

SPECIAL ENROLLMENT PERIOD: LOSS OF ELIGIBILITY FOR OTHER COVERAGE

An ***employee*** or ***dependent*** who did not enroll for coverage under this ***Plan*** because he was covered under other group coverage or had health coverage at the time he was initially eligible for coverage under this ***Plan***, may request a special enrollment period if he is no longer eligible for the other coverage. The ***employer*** may require proof of the Special Enrollment event noted below. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

1. Legal separation or divorce;

2. A ***dependent*** child loses eligibility, for example, due to reaching the maximum age.

3. Death of spouse who had the coverage under the other plan;

4. Termination of other employment or reduction in number of hours of other employment;

5. Termination of the other coverage (including exhaustion of COBRA benefits);

6. Cessation of employer contributions toward the other coverage;

7. An individual in an HMO or other arrangement no longer resides, lives or works in the service area.

The end of any extended benefits period which has been provided due to any of the above will also be considered a loss of eligibility.

However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage.)

The ***employee*** or ***dependent*** must request the special enrollment and enroll no later than thirty (30) days from the date of loss of other coverage.

The effective date of coverage as the result of a special enrollment shall be the first day of the first calendar month following the ***employer's*** receipt of the completed enrollment form.

SPECIAL ENROLLMENT PERIOD: DEPENDENT ACQUISITION

An ***employee*** who is not covered under the ***Plan***, but who acquires a new ***dependent*** may request a special enrollment period. The ***employer*** may require proof of the Special Enrollment event noted below. For the purposes of this provision, the acquisition of a new ***dependent*** includes:

1. Marriage;

2. Birth of a ***dependent*** child;

3. Adoption or placement for adoption of a ***dependent*** child.

The ***employee*** must request the special enrollment within thirty (30) days of the acquisition of the ***dependent.***

The effective date of coverage as the result of a special enrollment shall be:

1. In the case of marriage, the first day of the first calendar month following the ***employer's*** receipt of the completed enrollment form;

2. In the case of a ***dependent's*** birth, the date of such birth;

3. In the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

SPECIAL ENROLLMENT PERIOD: MEDICAID AND CHIP ELIGIBILITY

An eligible ***employee,*** or an ***employee's*** eligible ***dependent,*** who is not enrolled under the ***Plan,*** shall be permitted to enroll for coverage hereunder if either of the following conditions are met:

1. Termination of Medicaid or CHIP Coverage: If the ***employee*** or ***dependent*** is covered under a state Medicaid plan under Title XIX of the Social Security Act, or under a state child health plan under Title XXI of the Social Security Act, and coverage of the ***employee*** or ***dependent*** under such other coverage is terminated as a result of loss of eligibility for such coverage.

2. Eligibility for Premium Assistance Under Medicaid or CHIP: If the ***employee*** or ***dependent*** becomes eligible for premium assistance, with respect to coverage under this ***Plan***, under a Medicaid plan or state child health plan.

The ***employee*** or ***dependent*** must submit a completed application for enrollment to the ***employer*** within sixty (60) days of either: (1) termination of coverage under such other coverage, or (2) the date the ***employee*** or ***dependent*** is determined to be eligible for premium assistance. Failure to submit the completed application for enrollment within the designated time shall result in the ***employee's*** or ***dependent's*** forfeiture of this enrollment right and shall be subject to enrolling upon the next open enrollment period sponsored by the ***employer***.

OPEN ENROLLMENT APPLIES TO MONTHLY MEASUREMENT PERIOD METHOD EMPLOYEES ONLY

Open enrollment is the period designated by the ***employer*** during which the ***employee*** may elect coverage for himself and any eligible ***dependents*** if he is not covered under the ***Plan*** and does not qualify for a Special Enrollment as described herein. Enrolled ***employees*** may add or drop coverage for enrolled ***dependents*** during this open enrollment period.

An open enrollment will be permitted once in each ***benefit year*** during a period selected by the ***employer***. Coverage changes shall be effective on the first day of the month following the open enrollment period, provided a properly completed application for enrollment is submitted to the ***employer*** during the designated open enrollment period and must be received by the ***employer*** by the last day of the open enrollment period.

ADMINISTRATIVE PERIOD APPLIES TO THE LOOK BACK MEASUREMENT PERIOD ONLY

The ***administrative period*** is the period designated by the ***employer*** during which the ***employee*** may elect coverage for himself and any eligible ***dependents.*** An ***administrative period*** will follow each ***measurement period. Ongoing employees*** may add or drop coverage for themselves or enrolled ***dependents,*** or may change benefit plan options for himself or any enrolled ***dependents*** during this ***administrative period***.

Coverage changes shall be effective on the first day of the following ***stability period***, provided a properly completed application for enrollment is submitted to the ***employer*** during the designated ***administrative period.***

LATE ENROLLMENT

With the exception of the provisions identified in *Special Enrollment* above, applications for ***employee*** or ***dependent*** coverage which are **not** filed with the ***employer*** within thirty (30) days of meeting the eligibility requirements of the ***Plan*** shall be subject to this late enrollment provision.

Late enrollment applicants shall be eligible to enroll for coverage during the ***Plan's*** annual open enrollment period. Coverage shall become effective the first of the month following the open enrollment period provided a properly completed application for enrollment has been received by the ***employer***. This late enrollment provision shall not apply to an ***alternate recipient.***

WAIVER OF COVERAGE

Employees who elect not to enroll themselves and/or their ***dependents*** must complete a waiver of coverage form. The waiver of coverage must be submitted to the ***employer*** within thirty (30) days of the date coverage would otherwise be effective under this ***Plan.*** If waiver of coverage is due to the existence of other group health coverage upon meeting the ***Plan's*** eligibility requirements, it is the ***employee's*** responsibility to notify the ***employer*** in writing of the existence of the other coverage and this is the reason for waiving coverage upon meeting the eligibility requirements.

EFFECTIVE DATE OF COVERAGE

EMPLOYEE(S) EFFECTIVE DATE

If the ***employee*** does not enroll for coverage within thirty (30) days of meeting the ***Plan's*** eligibility requirements, the ***effective date*** of coverage will be delayed. Refer to the section entitled, *Enrollment.*

NEW HIRES

Full-time, Regular Employees on the Monthly Measurement or Look Back Measurement Period Method

Eligible ***full-time, regular employees,*** as described in, *Eligibility,* are covered under the ***Plan*** on the first of the month following a sixty (60) day waiting period, provided a properly completed enrollment form was submitted to the ***employer.***

If the ***employee*** does not enroll for coverage within thirty (30) days of meeting the ***Plan's*** eligibility requirements, the ***effective date*** of coverage will be delayed. Refer to *Enrollment*.

Part-time Employees on the Monthly Measurement Period Method

In the event a ***part-time employee*** changes employment status to ***full-time, regular employee,*** coverage will be effective on the first day of the month following the date the ***employee*** meets the ***Plan's*** eligibility requirements, provided the ***employee*** worked in a ***part-time*** capacity for the ***employer*** for at least the period of time equal to the ***Plan's*** waiting period, and provided a properly completed application or enrollment to the ***employer.***

Qualifying Part-time Employees on the Look Back Measurement Period

Eligible ***qualifying part-time employees*** will be effective on the first day of the ***qualifying part-time employee's new employee stability period*** provided a properly completed application for enrollment was submitted to the ***employer*** by the end of the ***administrative period.*** A ***qualifying part-time employee*** will remain eligible throughout the ***new employee stability period*** and therefore, covered under the ***Plan,*** to the extent that the ***employee*** remains employed, subject to the ***Plan's break in service*** rules, and *Termination of Coverage* provisions of the ***Plan.***

ONGOING EMPLOYEES ON THE LOOK BACK MEASUREMENT PERIOD METHOD

Eligible ***ongoing employees*** will be effective on the first day of the ***Plan's ongoing employee stability period,*** provided a properly completed application for enrollment was submitted to the ***employer*** by the end of the ***administrative period.***

DEPENDENT(S) EFFECTIVE DATE

Eligible ***dependent(s),*** as described in *Eligibility,* will become covered under the ***Plan*** on the later of the dates listed below, provided the ***employee*** has enrolled them in the ***Plan*** within thirty (30) days of meeting the ***Plan's*** eligibility requirements. If the ***employee*** does not enroll eligible ***dependents*** within thirty (30) days of meeting the ***Plan's*** eligibility requirements, the ***dependents' effective date*** of coverage will be delayed. Refer to *Enrollment*.

1. The date the ***employee's*** coverage becomes effective.

2. The date the ***dependent*** is acquired, provided any required contributions are made and the ***employee*** has applied for ***dependent*** coverage within thirty (30) days of the date acquired.

3. Newborn children shall be covered from birth, regardless of ***confinement,*** provided the ***employee*** has applied for ***dependent*** coverage within thirty (30) days of birth. However, if the ***employee*** already has other ***dependents*** covered under this ***Plan*** when a child is born, additional enrollment for that child will be required.

4. Coverage for a newly adopted child shall be effective on the date the child is ***placed for adoption.***

TERMINATION OF COVERAGE

Except as provided in the ***Plan's*** *Continuation of Coverage* (COBRA) provision, coverage will terminate on the earliest of the following dates:

EMPLOYEE(S) TERMINATION DATE

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health plan.

2. The last day of the month in which the ***employee*** ceases to meet the eligibility requirements of the ***Plan.***

3. The last day of the month in which employment terminates.

4. The date the ***employee*** becomes a ***full-time,*** active member of the armed forces of any country.

5. The date the ***employee*** ceases to make any required contributions.

DEPENDENT(S) TERMINATION DATE

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health plan.

2. The date the ***employee's*** coverage terminates. However, if the ***employee*** remains eligible for the ***Plan,*** but elects to discontinue coverage, coverage may be extended for ***alternate recipients.***

3. The date such person ceases to meet the eligibility requirements of the ***Plan.***

4. The date the ***employee*** ceases to make any required contributions on the ***dependent's*** behalf.

5. The date the ***dependent*** becomes a ***full-time,*** active member of the armed forces of any country.

6. The date the ***Plan*** discontinues ***dependent*** coverage for any and all ***dependents.***

LEAVE OF ABSENCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***employees*** and/or ***dependents,*** when the ***employee*** is on an authorized ***leave of absence*** from the ***employer.*** In no event will coverage continue beyond the end of the twelve (12) calendar week period that next follows the month in which the person last worked as an active ***employee***.

LAYOFF

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***employees*** and/or ***dependents,*** when the ***employee*** is subject to an ***employer layoff.*** In no event will coverage continue beyond the end of the twelve (12) calendar week period that next follows the month in which the person last worked as an active ***employee***.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

An ***employee*** who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under this ***Plan*** while on an approved leave. The duration of leave is contingent upon the reason for the leave as follows:

1. Up to twelve (12) workweeks during a twelve (12) month period:
   - A. for the birth and care of the newborn child of the ***employee***;
   - B. for placement with the ***employee*** of a son or daughter for adoption or foster care;
   - C. to care for an immediate family member (spouse, child, or parent) with a serious health condition; or
   - D. to take medical leave when the ***employee*** is unable to work because of a serious health condition.

For the purposes of this provision, the above shall be referred to as: Other FMLA Qualifying Reasons.

2. Up to twenty-six (26) workweeks during a twelve (12) month period to care for a service member who is undergoing medical treatment, recuperation, or therapy, is otherwise in an outpatient status or is otherwise on temporary disability retired list for a serious ***injury*** or ***illness*** incurred in the line of duty on active duty. For the purpose of the provision, "service member" is defined as a current member of the Armed Forces, including a member of the National Guard or Reserves. This shall be referred to as: Military Caregiver Leave.
3. Up to twelve (12) workweeks during a twelve (12) month period due to a spouse, son, daughter, or parent who is a member of one of the U.S. Armed Force's Reserve components or National Guard on active duty or is a reservist or member of the National Guard who faces recall to active, federal service by the President if a qualifying exigency exists. This shall be referred to as: Qualifying Exigency Leave.

An ***employee*** who is eligible for FMLA leave is entitled to a combined total of twenty-six (26) workweeks of leave for Military Caregiver Leave and leave for any Other FMLA Qualifying Reason during the same single 12-month period provided that the ***employee*** takes no more than twelve (12) workweeks of leave because of a Qualifying Exigency Leave or for any Other FMLA Qualifying Reason.

Contributions

During this leave, the ***employer*** will continue to pay the same portion of the ***employee's*** contribution for the ***Plan.*** The ***employee*** shall be responsible to continue payment for eligible ***dependent's*** coverage and any remaining ***employee*** contributions. If the covered ***employee*** fails to make the required contribution during a FMLA leave within thirty (30) days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.

Reinstatement

If coverage under the ***Plan*** was terminated during an approved FMLA leave, and the ***employee*** returns to active work immediately upon completion of that leave, ***Plan*** coverage will be reinstated on the date the ***employee*** returns to active work as if coverage had not terminated, provided the ***employee*** makes any necessary contributions and enrolls for coverage within thirty (30) days of his return to active work.

Repayment Requirement

The ***employer*** may require ***employees*** who fail to return from a leave under FMLA to repay any contributions paid by the ***employer*** on the ***employee's*** behalf during an unpaid leave. This repayment will be required only if the ***employee's*** failure to return from such leave is not related to a "serious health condition," as defined in FMLA, or events beyond the ***employee's*** control.

CONTINUATION OF COVERAGE

In order to comply with federal regulations, this ***Plan*** includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Public Health Services Act. This continuation of coverage may be commonly referred to as "COBRA coverage."

The coverage which may be continued under this provision consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes medical, prescription drug, dental and vision benefits as provided under the ***Plan.***

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a ***covered person*** to lose coverage under this ***Plan,*** even if such coverage is not lost immediately, and allow such person to continue coverage beyond the date described in *Termination of Coverage:*

1. Death of the ***employee.***

2. The ***employee's*** termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the ***Plan.***

3. Divorce or legal separation from the ***employee.***

4. The ***employee's*** entitlement to ***Medicare*** benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this ***Plan.***

5. A ***dependent*** child no longer meets the eligibility requirements of the ***Plan.***

6. The last day of leave under the Family Medical Leave Act of 1993.

7. The call-up of an ***employee*** reservist to active duty.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered ***employee,*** or a child's loss of ***dependent*** status, the ***employee*** or ***dependent*** must notify the ***employer*** of that event within sixty (60) days of the event**. Failure to provide such notice to the *employer* will result in the person forfeiting their rights to continuation of coverage under this provision.**

2. The ***employer*** has thirty (30) days to notify the ***claims administrator*** of the qualifying event. Within fourteen (14) days of receiving notice of a qualifying event, the ***claims administrator*** will notify the ***employee*** or ***dependent*** of his rights to continuation of coverage, and what process is required to elect continuation of coverage.

3. After receiving notice, the ***employee*** or ***dependent*** has sixty (60) days to decide whether to elect continued coverage. Each person who was covered under the ***Plan*** prior to the qualifying event, has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the ***employee*** or ***dependent*** chooses to have continued coverage, he must advise the ***employer*** in writing of this choice. The ***employer*** must receive this written notice no later than the last day of the sixty (60) day period. If the election is mailed, the election must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the latter of the following:

   A. The date coverage under the ***Plan*** would otherwise end; or

B. The date the person receives the notice from the ***employer*** of his or her rights to continuation of coverage.

4. Within forty-five (45) days after the date the person notifies the ***employer*** that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continued coverage are to be made monthly, and are due in advance, on the first day each month.

5. The ***employee*** or ***dependent*** must make payments for the continued coverage.

COST OF COVERAGE

1. The ***employer*** requires that ***covered persons*** pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. This must be remitted to the ***employer*** or the ***employer's*** designated representative, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the coverage in force.

2. For purposes of determining monthly costs for continued coverage, a person originally covered as an ***employee*** or as a spouse will pay the rate applicable to an ***employee*** if coverage is continued for himself alone. Each child continuing coverage independent of the family unit will pay the rate applicable to an ***employee.***

WHEN CONTINUATION COVERAGE BEGINS

When continuation coverage is elected and the contributions paid within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for ***dependents*** acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the ***Plan.***

Since a reduction in employment hours is a qualifying event under this provision, any continuation of coverage granted by the ***employer*** (***leave of absence, layoff,*** shall run simultaneously with the continuation of coverage provided under this provision (COBRA).

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A spouse or ***dependent*** child newly acquired during continuation coverage is eligible to be enrolled as a ***dependent.*** The standard enrollment provision of the ***Plan*** applies to enrollees during continuation coverage. A ***dependent*** acquired and enrolled after the original qualifying event, other than a child born to or ***placed for adoption*** with a covered ***employee*** during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

SUBSEQUENT QUALIFYING EVENTS

Once covered under continuation coverage, it is possible for a second qualifying event to occur, including:

1. Death of an ***employee.***

2. Divorce or legal separation from an ***employee.***

3. ***Employee's*** entitlement to ***Medicare.***

4. The child's loss of ***dependent*** status.

If one of these subsequent qualifying events occurs, a ***dependent*** may be entitled to a second continuation period. This period will in no event continue beyond thirty-six (36) months from the date of the first qualifying event.

Only a person covered prior to the original qualifying event or a child born to or ***placed for adoption*** with a covered ***employee*** during a period of COBRA continuation is eligible to continue coverage again as the result of a subsequent qualifying event. Any other ***dependent*** acquired during continuation coverage is not eligible to continue coverage as the result of a subsequent qualifying event.

END OF CONTINUATION

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen (18) months from the date continuation began because of a reduction of hours or termination of employment of the ***employee.***

2. Thirty-six (36) months from the date continuation began for ***dependents*** whose coverage ended because of the death of the ***employee,*** divorce or legal separation from the ***employee,*** or the child's loss of ***dependent*** status.

3. The end of the period for which contributions are paid if the ***covered person*** fails to make a payment on the date specified by the ***employer.***

4. The date coverage under this ***Plan*** ends and the ***employer*** offers no other group health benefit plan.

5. The date the ***covered person*** first becomes entitled to ***Medicare*** after the original date of the ***covered person's*** election of continuation coverage.

6. The date the ***covered person*** first becomes covered under any other group health plan after the original date of the ***covered person's*** election of continuation coverage.

EXTENSION FOR DISABLED INDIVIDUALS

A person who is ***totally disabled*** may extend continuation coverage from eighteen (18) months to twenty-nine (29) months. The person must be disabled for Social Security purposes at the time of the qualifying event or within sixty (60) days thereafter. The disabled person must submit proof of the determination of disability by the Social Security Administration to the ***employer*** within the initial eighteen (18) month continuation coverage period and no later than sixty (60) days after the Social Security Administration's determination. The disabled person and the family members who were covered prior to the qualifying event are eligible for up to twenty-nine (29) months of continuation of coverage. The ***employer*** may charge 150% of the contribution during the additional eleven (11) months of continuation of coverage. Extended coverage will end the month that begins thirty (30) days after the person is no longer considered disabled.

MILITARY MOBILIZATION

If an ***employee*** is called for active duty by the United States Armed Services (including the Coast Guard), the National Guard or the Public Health Service, the ***employee*** may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the ***employee*** may not be required to pay more than the ***employee's*** share, if any, applicable to that coverage. If the leave is more than thirty-one (31) days, then the ***employer*** may require the ***employee*** to pay no more than 102% of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or

2. A period beginning on the day that the leave began and ending on the day after the ***employee*** fails to return to employment within the time allowed.

Whether or not the individual elects continuation of coverage under USERRA, upon return from uniformed service, the ***employee's*** coverage will be reinstated the date of return to work, provided the uniformed service member was released under honorable conditions, and returns to work within the following timelines:

1. Following completion of the military service for a leave of less than thirty-one (31) days, upon the first full regularly scheduled work period after the expiration of eight (8) hours after a period allowing for the safe transportation of the person from the place of service to the person's residence.

2. Within fourteen (14) days of completing military service for a leave of thirty-one (31) days to one hundred eighty (180) days;

3. Within ninety (90) days of completing military service for a leave of more than one hundred eighty (180) days.

The ***Plan*** shall be reinstated without exclusions other than for a period or exclusions that would have applied even if there had been no absence for uniformed service.

CLAIM FILING PROCEDURE

FILING A CLAIM

1. A claim form is to be completed on each covered family member at the beginning of the ***benefit year*** and for each claim involving an ***injury***. Appropriate claim forms are available from the Human Resources Department.

2. All bills submitted for benefits must contain the following:

   A. Name of patient.
   B. Patient's date of birth.
   C. Name of ***employee.***
   D. Address of ***employee.***
   E. Name of ***employer.***
   F. Name, address and tax identification number of provider.
   G. ***Employee*** Social Security number.
   H. Date of service.
   I. Diagnosis.
   J. Description of service and procedure number.
   K. Charge for service.
   L. The nature of the accident, Injury or Illness being treated.

3. Properly completed claims not submitted within one (1) year of the date of incurred liability will be denied.

The ***covered person*** may ask the provider to submit the bill directly to the ***claims processor,*** or the ***covered person*** may file the bill with a claim form. However, it is ultimately the ***covered person's*** responsibility to make sure the claim has been filed for benefits.

Proof of Payment of Deductible

To obtain benefits under this ***Plan,*** the ***covered person*** must submit proof to the ***claims processor*** that the deductible for the ***benefit year*** has been incurred. Proof will include an itemized bill on the provider's letterhead or statement and the diagnosis.

FOREIGN CLAIMS

In the event a ***covered person*** incurs a ***covered expense*** in a foreign country, the ***covered person*** shall be responsible for providing the following to the ***claims processor*** before payment of any benefits due are payable:

1. The claim form, provider invoice and any other documentation required to process the claim must be submitted in the English language.

2. The charges for services must be converted into dollars.

3. A current conversion chart validating the conversion from the foreign country's currency into dollars.

NOTICE OF CLAIM

A claim for benefits should be submitted to the ***claims processor*** within ninety (90) days after the occurrence or commencement of any services covered by the ***Plan,*** or as soon thereafter as reasonably possible. Benefits are based on the ***Plan's*** provisions at the time the expenses were incurred.

Failure to file a claim within the time provided shall not invalidate or reduce any claim if it shall be shown that: (1) it was not reasonably possible to file a claim within that time; (2) and that such claim was furnished as soon as possible, but no later than one (1) year after the loss occurs or commences, unless the claimant is legally incapacitated.

Notice given by or on behalf of a ***covered person*** or his beneficiary, if any, to the ***Plan administrator*** or to any authorized agent of the ***Plan*** with information sufficient to identify the ***covered person,*** shall be deemed notice of claim.

PAYMENT OF BENEFITS

After a claim has been submitted to the ***claims processor,*** if additional information is needed for payment of the claim, the ***claims processor*** will request the same. The ***claims processor*** will approve, partially approve, or deny the claim within thirty (30) days after all necessary information is received by the ***claims processor*** to determine the validity of the claim. This time period may be extended for fifteen (15) days if it is necessary because of matters beyond the ***Plan's*** control, and if the ***Plan*** notifies the ***covered person*** of those circumstances and the expected date of decision before the end of the thirty (30) day period. This Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. The ***employee*** will be allowed up to forty-five (45) calendar days from receipt of the Notice of Extension to provide the additional information. The ***Plan*** will then make a claim determination within a reasonable period but not later than fifteen (15) calendar days from the date the ***Plan*** receives the additional information.

If the services of a ***preferred provider*** are used, ***Plan*** benefits are payable directly to the provider of service. If the services of a ***nonpreferred provider*** are used, benefits are payable to the ***covered person*** whose ***illness*** or ***injury,*** or whose ***dependent's illness*** or ***injury,*** is the basis of claim under this ***Plan,*** unless the ***covered person*** has made an assignment of benefits to the provider of service.

In the event a claim for benefits under the ***Plan*** is denied in whole or in part, the ***covered person*** will receive written notification stating the required information including the review procedure, in the same fashion as reimbursement for a claim, in a manner calculated to be understood by the ***covered person.*** A claim worksheet will be provided by the ***claims processor*** showing the calculation of the total amount payable, charges not payable, and the reason.

APPEALING A CLAIM

Review Procedures

A ***covered person,*** or the ***covered person's*** representative may request a review of the claim denial by making written request to the ***claims processor*** within one-hundred-eighty (180) days of receipt of the notice of denial. Written notice for review should:

1. State the reasons the ***covered person*** feels the claim should not have been denied; and

2. Include any additional documentation which the ***covered person*** believes supports the claim.

On receipt of written request for review of a claim, the ***claims processor*** will review the claim and furnish copies to the ***employer*** of all documents and all reasons and facts relative to the decision. An ***employee,*** or his authorized representative, may examine all pertinent documents which the ***claims processor*** may have, excluding any medical records of a confidential nature, and submit an opinion in writing of the issues and his comments to the ***employer.***

Decision on Review

Decision by the ***employer*** will be made within sixty (60) days of receipt of the written opinion unless special circumstances require more time, then the decision shall be rendered as soon as possible, but no later than one-hundred-twenty (120) days after receipt of the ***covered person's*** request for review. This decision will also be delivered to the ***covered person*** in writing, setting forth specific reasons for the decision and specific references to the pertinent ***Plan*** provisions upon which the decision is based. The decision is final.

INTERNAL AND EXTERNAL APPEAL PROCESS

The ***Plan*** shall maintain an Internal Appeals and an External Appeals Process in accordance with the following:

Internal Appeals Process

1. Clarification of "Adverse Benefit Determination": The scope of an "adverse benefit determination" eligible for internal claims and appeals includes a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time).

2. Full and Fair Review: The ***Plan*** shall provide a ***covered person*** (free of charge) any new or additional evidence considered, relied upon or generated by the ***Plan*** in connection with a claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the ***covered person*** to respond to such new evidence or rationale before a final adverse benefit determination is made.

3. Avoidance of Any Conflict of Interest: The ***Plan*** must ensure any decisions related to hiring, compensation, termination, promotion or other similar matters with respect to any individual in the claims decision process, such as a ***claims processor*** or medical expert, may not be based on the likelihood that the individual will support the denial of benefits.

4. Notices - Content Requirements: Any notice of an adverse benefit determination or final internal adverse benefit determination must include the following:

   A. Claim Identification. Information sufficient to identify the claim involved, including the date of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

   B. Rationale for Denial. The reason or reasons for an adverse benefit determination including the denial code and its corresponding meaning and a description of the standard(s) applied in denying the claim. A notice of a final internal adverse benefit determination must also include a discussion of the decision.

   C. Claims and Appeal Procedures. The ***Plan*** must provide a description of the available internal and external review processes (including information on how to initiate an appeal).

   D. Consumer Assistance. The ***Plan*** must disclose the availability of and contact information for any outside applicable office to assist ***covered persons*** with the claims, appeals, and external review processes.

5. Deemed Exhaustion of Internal Claims and Appeals Processes: If the ***Plan*** fails to strictly adhere to all requirements of the Internal Claims and Appeals, a ***covered person*** will be deemed to have exhausted the internal claims and appeals process, regardless of whether the ***Plan*** asserts that it has substantially complied, and the ***covered person*** may initiate any available external review process or remedies available at law.

Standard External Appeals Process

1. Request for External Review: The ***Plan*** will allow a ***covered person*** to file a request for an external review if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth (5th) month following the receipt of the notice. (For example, if the date of receipt of the notice is October 30th, because there is no February 30th, the request must be filed by March 1st). If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary Review: Within five (5) business days following the date of receipt of the external review request, the ***Plan*** will complete a preliminary review of the request to determine whether:

A. The ***covered person*** is or was covered under the ***Plan*** at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the ***Plan*** at the time the health care item or service was provided;

B. The adverse benefit determination or the final adverse benefit determination does not relate to the ***covered person's*** failure to meet the requirements for eligibility under the terms of the ***Plan***.

C. The ***covered person*** has exhausted the ***Plan's*** internal appeal process.

D. The ***covered person*** has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the ***Plan*** will issue a notification in writing to the ***covered person*** or the ***covered person's*** authorized representative. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272). If the request is not complete, such notification will include the information or materials needed to make the request complete and the ***Plan*** will allow a ***covered person*** to perfect the request for external review within the four (4) month filing period or within the forty-eight (48) hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization (IRO): The ***Plan*** will assign an independent review organization (IRO) that is accredited by URAC or by similar nationally recognized accrediting organization to conduct the external review. The ***Plan*** will also take action to ensure against bias and to ensure independence. To do this, the ***Plan*** will contract with at least three (3) IROs for assignments under the ***Plan*** and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). An IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Minimum Standards for IRO Contract: A contract between the ***Plan*** and an IRO must provide the following:

A. The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the ***Plan.***

B. The assigned IRO will timely notify the ***covered person*** in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the ***covered person*** may submit in writing to the assigned IRO within ten (10) business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days.

C. Within five (5) business days after the date of assignment of the IRO, the ***Plan*** must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the ***Plan*** to timely provide the documents and information must not delay the conduct of the external review. If the ***Plan*** fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one (1) business day after making the decision, the IRO must notify the ***covered person*** and the ***Plan***.

D. Upon receipt of any information submitted by the ***covered person***, the assigned IRO must within one (1) business day forward the information to the ***Plan***. Upon receipt of any such information, the ***Plan*** may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the ***Plan*** must not delay the external review. The external review may be terminated as a result of the reconsideration only if the ***Plan*** decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one (1) business day after making such a decision, the ***Plan*** must provide written notice of its decision to the ***covered person*** and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the ***Plan***.

E. The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the ***Plan's*** internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the PHS Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

i. The ***covered person***'s medical records;
ii. The attending health care professional's recommendation;
iii. Reports from appropriate health care professionals and other documents submitted by the plan or issuer, ***covered person***, or ***covered person***'s treating provider;
iv. The terms of the ***covered person***'s ***Plan*** to ensure that the IRO's decision is not contrary to the terms of the ***Plan***, unless the terms are inconsistent with applicable law;
v. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
vi. Any applicable clinical review criteria developed and used by the ***Plan***, unless the criteria are inconsistent with the terms of the ***Plan*** or with applicable law; and
vii. The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

F. The assigned IRO must provide written notice of the final external review decision within forty-five (45) days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the ***covered person*** and the ***Plan***.

G. The assigned IRO's decision notice will contain:

i. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
ii. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
iii. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
iv. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the ***covered person***;
v. A statement that judicial review may be available to the ***covered person***; and
vi. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHA Act section 2793.

H. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the ***covered person***, ***Plan***, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

5. Reversal of ***Plan's*** Decision: Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the ***Plan*** immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Reviews

1. Request for Expedited External Review: The ***Plan*** must allow a ***covered person*** to make a request for an expedited external review with the ***Plan*** at the time the ***covered person*** receives:

A. An adverse benefit determination if the adverse benefit determination involves a medical condition of the ***covered person*** for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the life or health of the ***covered person*** or would jeopardize the ***covered person***'s ability to regain maximum function and the ***covered person*** has filed a request for an expedited internal appeal; or

B. A final internal adverse benefit determination, if the ***covered person*** has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the ***covered person*** or would jeopardize the ***covered person***'s ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the ***covered person*** received ***emergency*** services, but has not been discharged from a ***facility***.

2. Preliminary Review: Immediately upon receipt of the request for expedited external review, the ***Plan*** must determine whether the request meets the reviewability requirements set forth in paragraph 2 above for standard external review. The ***Plan*** must immediately send a notice that meets the requirements set forth in paragraph 2 above for standard external review to the ***covered person*** of its eligibility determination.

3. Referral to Independent Review Organization: Upon a determination that a request is eligible for external review following the preliminary review, the ***Plan*** will assign an IRO pursuant to the above requirements for standard review. The ***Plan*** must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the ***Plan's*** internal claims and appeals process.

4. Notice of Final External Review Decision: The ***Plan's*** contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the ***covered person***'s medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the ***covered person*** and the ***Plan***.

COORDINATION OF BENEFITS

The *Coordination of Benefits* provision is intended to prevent duplication of benefits. It applies when the ***covered person*** is also covered by any Other Plan(s). When more than one coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plan, pays a reduced benefit. When coordination of benefits occurs, the total benefit payable by all plans will not exceed 100% of "allowable expenses." Only the amount paid by this ***Plan*** will be charged against the ***maximum benefit.***

The *Coordination of Benefits* provision applies whether or not a claim is filed under the Other Plan(s). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

"Allowable Expenses" means any reasonable, necessary, and customary expenses incurred while covered under this ***Plan,*** part or all of which would be covered under this ***Plan***. Allowable Expenses do not include expenses contained in the "Exclusions" sections of this ***Plan.***

When this ***Plan*** is secondary, "Allowable Expense" will include any deductible or ***coinsurance*** amounts not paid by the Other Plan(s).

When this ***Plan*** is secondary, "Allowable Expense" shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the ***covered person*** for the difference between the provider's contracted amount and the provider's regular billed charge.

"Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for ***covered persons*** in a group, whether on an insured or uninsured basis, including, but not limited to, hospital indemnity benefits and hospital reimbursement-type plans;

2. Hospital or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;

3. A licensed Health Maintenance Organization (HMO);

4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;

5. Any coverage under a government program and any coverage required or provided by any statute;

6. Group automobile insurance;

7. Individual automobile insurance coverage;

8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;

9. Any plan or policies funded in whole or in part by an ***employer,*** or deductions made by an ***employer*** from a person's compensation or retirement benefits;

10. Labor/management trustee, union welfare, employer organization, or employee benefit organization plans.

"This ***Plan"*** shall mean that portion of the ***employer's Plan*** which provides benefits that are subject to this provision.

"Claim Determination Period" means a ***benefit year*** or that portion of a ***benefit year*** during which the ***covered person*** for whom a claim is made has been covered under this ***Plan.***

AUTOMOBILE LIMITATIONS

When medical payments are available under vehicle insurance, the ***Plan*** shall pay excess benefits only, without reimbursement for vehicle plan deductibles. The ***Plan*** shall always be considered the secondary carrier regardless of the individual's election under personal injury protection with the auto insurance carrier.

EFFECT ON BENEFITS

This provision shall apply in determining the benefits for a ***covered person*** for each claim determination period for the Allowable Expenses. If this ***Plan*** is secondary, the benefits that would be payable under this ***Plan*** for each claim in the absence of this provision shall be calculated and reduced by the benefits payable under all other plans for the expenses covered in whole or in part by this ***Plan***.

If the rules set forth below would require this ***Plan*** to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this ***Plan***.

ORDER OF BENEFIT DETERMINATION

Each plan will make its claim payment according to the following order of benefit determination:

1. No Coordination of Benefits Provision
   If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).

2. Member/Dependent
   The plan which covers the claimant as a member (or named insured) pays as though no Other Plan existed. Remaining ***covered expenses*** are paid under a plan which covers the claimant as a ***dependent.***

3. Dependent Children of Parents not Separated or Divorced
   The plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.

4. Dependent Children of Separated or Divorced Parents
   When parents are separated or divorced, the birthday rule does not apply, instead:

   A. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent pays fourth.
   B. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody pays fourth.

5. Active/Inactive
   The plan covering a person as an active (not laid off or retired) ***employee,*** or as that person's ***dependent*** pays first. The plan covering that person as a laid off or retired ***employee,*** or as that person's ***dependent*** pays second.

6. Limited Continuation of Coverage

If a person is covered under another group health plan, but is also covered under this ***Plan*** for continuation of coverage due to the Other Plan's exclusions, the Other Plan shall be primary for all ***covered expenses*** which are not related to the exclusions.

7. Longer/Shorter Length of Coverage
If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

COORDINATION WITH MEDICARE

Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for ***Medicare*** Part A at no cost. Participation in ***Medicare*** Part B is available to all individuals who make application and pay the full cost of the coverage.

1. When an ***employee*** becomes entitled to ***Medicare*** coverage and is still ***actively at work,*** the ***employee*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

2. When a ***dependent*** becomes entitled to ***Medicare*** coverage and the ***employee*** is still ***actively at work,*** the ***dependent*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

3. If the ***employee*** and/or ***dependent*** is also enrolled in ***Medicare,*** this ***Plan*** shall pay as the primary plan. ***Medicare*** will pay as secondary plan.

4. If the ***employee*** and/or ***dependent*** elect to discontinue health coverage under this ***Plan*** and enroll under the ***Medicare*** program, no benefits will be paid under this ***Plan.*** ***Medicare*** will be the only payor.

This section is subject to the standard terms of the ***Medicare*** Secondary Payor laws and regulations, including but not limited to, determination of first and second payor for a person with End Stage Renal Disease, or a person eligible for Medicare due to disability. Any changes in these related laws and regulations will apply to the provisions of this section.

LIMITATIONS ON PAYMENTS

In no event shall the ***covered person*** recover under this ***Plan*** and all Other Plan(s) combined more than the total Allowable Expenses offered by this ***Plan*** and the Other Plan(s). Nothing contained in this section shall entitle the ***covered person*** to benefits in excess of the total ***maximum benefits*** of this ***Plan*** during the claim determination period. The ***covered person*** shall refund to the ***employer*** any excess it may have paid.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this *Coordination of Benefits* provision, the ***Plan*** may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information with respect to any ***covered person.*** Any person claiming benefits under this ***Plan*** shall furnish to the ***employer*** such information as may be necessary to implement the *Coordination of Benefits* provision.

FACILITY OF BENEFIT PAYMENT

Whenever payments which should have been made under this ***Plan*** in accordance with this provision have been made under any Other Plan, the ***employer*** shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this ***Plan*** and, to the extent of such payments, the ***employer*** shall be fully discharged from liability.

SUBROGATION/REIMBURSEMENT

The ***Plan*** maintains the right to seek reimbursement on its own behalf: the right of subrogation. The ***Plan*** also reserves the right to reimbursement upon a ***covered person's*** (a covered ***employee*** or a covered dependent) receipt of settlement, judgment, or award: the right of reimbursement. The ***Plan*** reserves the right of recovery, either by subrogation or reimbursement, for ***covered expenses*** payable by the ***Plan*** which are a result of ***illness*** or ***injury***. The ***Plan*** shall be reimbursed from the first monies recovered as the result of judgment, settlement or otherwise. (This is known as "Pro tanto" subrogation.) This right includes the ***Plan's*** right to receive reimbursement from uninsured or underinsured motorist coverage and no-fault coverage.

Accepting benefits from this ***Plan*** automatically assigns to it any rights the ***covered person*** may have to recover benefits from any party, including an insurer or another group health program. This right of recovery allows the ***Plan*** to pursue any claim which the ***covered person*** may have against any party, group health program or insurer, whether or not the ***covered person*** chooses to pursue that claim. This includes a right to recover from no-fault auto insurance carriers in a situation where no third party may be liable, or from any uninsured or underinsured motorist coverage where the recovery was triggered by the actions of a party which caused or contributed to the payment of benefits under this ***Plan.*** This also includes a right to recover from amounts the ***covered person*** received from workers' compensation, whether by judgment or settlement, where the ***Plan*** has paid benefits prior to a determination that the medical expenses arose out of and in the course of employment. Payment by workers' compensation will be presumed to mean that such a determination has been made.

If a ***covered person*** is involved in an automobile accident, or suffers an ***illness*** or ***injury*** that was due to the action or inaction of any party, the ***Plan*** may advance payment in order to prevent any financial hardship to the ***covered person.*** Acceptance of ***Plan*** benefits acknowledges (1) the obligation of the ***covered person*** to help the ***Plan*** to recover benefits it has paid out on behalf of the ***covered person,*** and (2) to provide the ***Plan*** with information concerning: any automobile insurance, any other group health program which may be obligated to pay benefits on behalf of the ***covered person,*** and the insurance of any other party involved. The ***covered person*** is required to cooperate fully in the ***Plan's*** exercise of its right to recovery and the ***covered person*** cannot do anything to prejudice those rights. Such cooperation is required as a condition of receiving benefits under the ***Plan.*** The ***Plan administrator*** may refuse to pay benefits, or cease to pay benefits, on behalf of a ***covered person*** who fails to sign any document deemed by the ***Plan administrator*** to be relevant to protecting its subrogation rights or fails to provide relevant information when requested. The term information includes any documents, insurance policies, police reports, or any reasonable request by the ***claims processor*** or ***Plan administrator*** to enforce the ***Plan's*** rights.

Whether the ***covered person*** or the ***Plan*** makes a claim directly against any party, group health program or insurance company for the benefit payments made on behalf of a ***covered person*** by the ***Plan,*** the ***Plan*** has a lien on any amount the ***covered person*** recovers or could recover from any party, insurance company, or group health program whether by judgment, settlement, or otherwise, and whether or not designated as payment for medical expenses. This lien shall remain in effect until the ***Plan*** acknowledges and agrees upon payment to the ***Plan*** and releases its lien. The lien may not be for an amount greater than the amount of benefits paid under the ***Plan.***

Failure to reimburse the ***Plan*** for ***covered expenses*** paid by the ***Plan*** that were also paid by a third party otherwise responsible shall result in a reduction of future claim benefits of a ***covered person*** up to the aggregate amount the ***Plan*** has paid.

The ***Plan administrator*** has delegated to the ***claims processor*** the right to perform ministerial functions required to assert the ***Plan's*** rights; however, the ***Plan administrator*** shall retain discretionary authority with regard to asserting the ***Plan's*** recovery rights.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The ***Plan*** is administered through the Human Resources Department of the ***employer.*** The ***employer*** is the ***Plan administrator.*** The ***Plan administrator*** shall have full charge of the operation and management of the ***Plan.*** The ***employer*** has retained the services of an independent ***claims processor*** experienced in claims review.

The ***employer*** is the named fiduciary of the ***Plan.*** As fiduciary, the ***employer*** maintains discretionary authority to review all denied claims for benefits under the ***Plan*** with respect to which it has been designated named fiduciary, including, but not limited to, the denial of certification of the ***medical necessity*** of ***hospital*** or medical services, supplies and treatment, to interpret the terms of the ***Plan,*** and to determine eligibility for and entitlement to ***Plan*** benefits in accordance with the terms of the ***Plan.***

ASSIGNMENT

The ***Plan*** will pay benefits under this ***Plan*** to the ***employee*** unless payment has been assigned to a ***hospital, physician,*** or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the ***Plan*** unless the ***claims processor*** is notified in writing of such assignment prior to payment hereunder. This ***Plan*** will pay benefits to the responsible party of an ***alternate recipient*** as designated in a qualified medical child support order.

Preferred providers normally bill the ***Plan*** directly. If services, supplies or treatment has been received from such a provider, benefits are automatically paid to that provider. The ***covered person's*** portion of the ***negotiated rate,*** after the ***Plan's*** payment, will then be billed to the ***covered person*** by the ***preferred provider.***

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible ***covered person*** is entitled to receive benefits under this ***Plan.*** Such right to benefits is not transferable.

CLERICAL ERROR

For termination of coverage for an ***employee's*** coverage or ***dependent*** coverage, the ***employer*** may make an adjustment of contributions on the next monthly billing of up to ninety (90) days retroactively after the error or delay is discovered and submitted to the ***claims processor.*** No adjustments will be made in coverage or contributions for more than ninety (90) days retroactively.

For implementation of coverage for an ***employee*** whose application for enrollment was not submitted to the ***claims processor*** by the ***employer*** within thirty (30) days of the eligibility date, the ***employee*** will be effective coincident with or on the first of the month following receipt by the ***claims processor*** of a properly completed application for enrollment.

For implementation of coverage for ***dependent*** coverage: In the event that ***employer*** payroll deductions for family coverage occurred and the application for enrollment of ***dependent*** coverage was not submitted to the ***claims processor,*** the ***employee*** and ***dependents*** shall be enrolled for coverage retroactively to the applicable date of coverage, provided proof of payroll deductions are submitted to the ***claims processor*** with the application for enrollment. ***Employees*** and ***dependents*** will be added retroactive to the original effective date following the completion of any waiting period. In the event that payroll records are not provided, ***dependents*** may be added at the next open enrollment period, and the ***employee's*** coverage will be effective first of the month following receipt of the completed application for enrollment by the ***claims processor.***

CONFORMITY WITH STATUTE(S)

Any provision of the ***Plan*** which is in conflict with statutes which are applicable to this ***Plan*** is hereby amended to conform to the minimum requirements of said statute(s).

EFFECTIVE DATE OF THE PLAN

The original ***effective date*** of this ***Plan*** is October 1, 2015.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this ***Plan*** shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a ***hospital*** or to make a free choice of the attending ***physician*** or ***professional provider.*** However, benefits will be paid in accordance with the provisions of this ***Plan,*** and the ***covered person*** will have higher out-of-pocket expenses if the ***covered person*** uses the services of a ***nonpreferred provider.***

INCAPACITY

If, in the opinion of the ***employer,*** a ***covered person*** for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the ***Plan*** of the qualification of a guardian or personal representative for his estate, the ***employer*** may on behalf of the ***Plan,*** at his discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the ***Plan's*** obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the ***employer*** or by the ***employee*** covered under this ***Plan*** shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this ***Plan*** or be used in defense to a claim unless they are contained in writing and signed by the ***employer*** or by the ***covered person,*** as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the benefits from the ***Plan*** prior to the expiration of sixty (60) days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the ***Plan.*** No such action shall be brought after the expiration of two (2) years from the date the expense was ***incurred,*** or one (1) year from the date a completed claim was filed, whichever occurs first.

LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the ***employer*** shall not be liable for any obligation of the ***covered person incurred*** in excess thereof. The ***employer*** shall not be liable for the negligence, wrongful act, or omission of any ***physician, professional provider, hospital,*** or other institution, or their employees, or any other person. The liability of the ***Plan*** shall be limited to the reasonable cost of ***covered expenses*** and shall not include any liability for suffering or general damages.

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the ***Plan administrator*** is unable to locate the ***covered person*** to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the ***covered person*** for the forfeited benefits within the time prescribed in *Claim Filing Procedure.*

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

The ***Plan*** will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a State plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a ***covered person*** or in determining or making any payment of benefits to that individual. The ***Plan*** will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and this ***Plan*** has a legal liability to make payments for the same services, supplies or treatment, payment under the ***Plan*** will be made in accordance with any State law which provides that the State has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the ***Plan.***

MISREPRESENTATION

If the ***covered person*** or anyone acting on behalf of a ***covered person*** makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the ***Plan,*** or otherwise misleads the ***Plan,*** the ***Plan*** shall be entitled to recover its damages, including legal fees, from the ***covered person,*** or from any other person responsible for misleading the ***Plan,*** and from the person for whom the benefits were provided. Any material misrepresentation on the part of the ***covered person*** in making application for coverage, or any application for reclassification thereof, or for service there under shall render the coverage under this ***Plan*** null and void.

In the event an ***employee*** enrolled in the ***Plan*** fraudulently or with intentional misrepresentation of a material fact, the coverage under this ***Plan*** shall be terminated upon a thirty (30) day advance, written notice to the ***employee.***

PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN

The ***Plan,*** at its own expense, shall have the right to require an examination of a person covered under this ***Plan*** when and as often as it may reasonably require during the pendency of a claim.

PLAN IS NOT A CONTRACT

The ***Plan*** shall not be deemed to constitute a contract between the ***employer*** and any ***employee*** or to be a consideration for, or an inducement or condition of, the employment of any ***employee.*** Nothing in the ***Plan*** shall be deemed to give any ***employee*** the right to be retained in the service of the ***employer*** or to interfere with the right of the ***employer*** to terminate the employment of any ***employee*** at any time.

PLAN MODIFICATION AND AMENDMENT

The ***employer*** may modify or amend the ***Plan*** from time to time at its sole discretion, and such amendments or modifications which affect ***covered persons*** will be communicated to the ***covered persons.*** Any such amendments shall be in writing, setting forth the modified provisions of the ***Plan,*** the ***effective date*** of the modifications, and shall be signed by the ***employer's*** designee.

An amendment to the ***Plan*** may be retroactively effective, but shall not adversely affect the rights of ***covered persons*** under this ***Plan*** for ***covered expenses*** provided after the effective date of the amendment but before the amendment is adopted.

Such modification or amendment shall be duly incorporated in writing into the master copy of the ***Plan*** on file with the ***employer,*** or a written copy thereof shall be deposited with such master copy of the ***Plan.***

PLAN TERMINATION

The ***employer*** reserves the right to terminate the ***Plan,*** in whole or in part, at any time. Upon termination, the rights of the ***covered persons*** to benefits are limited to claims ***incurred*** up to the date of termination. Any termination of the ***Plan*** will be communicated to the ***covered persons.***

Upon termination of this ***Plan,*** all claims ***incurred*** prior to termination, but not submitted to either the ***employer*** or ***claims processor*** within three (3) months of the ***effective date*** of termination of this ***Plan,*** will be excluded from any benefit consideration.

PRIVACY RULE

It is intended for the ***Plan*** to be in compliance with the requirements of § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy Rule" and § 164.504 (f) is referred to as "the 504" provisions") by establishing the extent to which the ***Plan sponsor*** will receive, use and /or disclose Protected Health Information (PHI).

Designation Of Person/Entity To Act On Plan's Behalf

The ***Plan*** has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the ***Plan*** designates the Human Resources Manager to take all actions required to be taken by the ***Plan*** in connection with the HIPAA Privacy Rule.

Disclosure of Protected Health Information (PHI) to the Plan Sponsor – Required Certification of Compliance by Plan Sponsor

1. Except as provided below with respect to the ***Plan's*** disclosure of summary health information, the ***Plan*** will (a) disclose PHI to the ***Plan Sponsor*** or (b) provide for or permit the disclosure of PHI to the ***Plan Sponsor*** by the ***claims processor*** with respect to the ***Plan***, *only if* the ***Plan*** has received a certification (signed on behalf of the ***Plan Sponsor***) that:

    A. The Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the ***Plan Sponsor***;

    B. The ***Plan Sponsor*** agrees to comply with the ***Plan*** provisions in relation to HIPAA Privacy Rules.

Permitted Disclosure of Individuals' Protected Health Information (PHI) to the Plan Sponsor

1. The ***Plan*** (and any business associates acting on behalf of the ***Plan***), or any health insurance issuer servicing the ***Plan*** will disclose individuals' PHI to the ***Plan Sponsor*** only to permit the ***Plan Sponsor*** to carry out plan administration functions.

2. All disclosures of the PHI of the ***Plan's covered persons*** by the ***Plan's*** business associate, or health insurance issuer to the ***Plan Sponsor*** will comply with the restrictions and requirements set forth herein.

3. The ***Plan*** (and any business associate acting on behalf of the ***Plan***), may not, and may not permit a health insurance issuer to, disclose individuals' PHI to the ***Plan Sponsor*** for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the ***Plan Sponsor***.

4. The ***Plan Sponsor*** will not use or further disclose individuals' PHI other than as described in the Plan Documents.

5. The ***Plan Sponsor*** will ensure that any agent(s), including a subcontractor, to whom it provides individuals' PHI received from the ***Plan*** (or from the ***Plan's*** health insurance issuer), agrees to the same restrictions and conditions that apply to the ***Plan Sponsor*** with respect to such PHI.

6. The ***Plan Sponsor*** will not use or disclose individuals' PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the ***Plan Sponsor.***

7. The ***Plan Sponsor*** will report to the **Plan** any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in the Plan Document of which the ***Plan Sponsor*** becomes aware.

Disclosure of Individuals' Protected Health Information - Disclosure by the Plan Sponsor

1. The ***Plan Sponsor*** will make the PHI of the individual who is the subject of the PHI available to such individual.

2. The ***Plan Sponsor*** will make individuals' PHI available for amendment and incorporate any amendments to individuals' PHI.

3. The ***Plan Sponsor*** will make and maintain an accounting so that it can make available those disclosures of individuals' PHI.

4. The ***Plan Sponsor*** will make its internal practices, books and records relating to the use and disclosure of individuals' PHI received from the ***Plan*** available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

5. The ***Plan Sponsor*** will, if feasible, return or destroy all individuals' PHI received from the Plan (or a health insurance with respect to the Plan) that the ***Plan Sponsor*** still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the ***Plan Sponsor*** will not retain copies of such PHI after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the ***Plan Sponsor*** will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

6. The ***Plan Sponsor*** will ensure that the required adequate separation, described below, is established and maintained.

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

1. The **Plan**, or a health insurance issuer with respect to the **Plan**, may disclose summary health information to the ***Plan Sponsor*** if the ***Plan Sponsor*** requests the summary health information for the purpose of:

    A. Obtaining premium bids from health plans for providing health insurance coverage under the ***Plan;*** or

    B. Modifying, amending, or terminating the ***Plan.***

2. The ***Plan***, or a ***claims processor*** with respect to the ***Plan***, may disclose enrollment and disenrollment information to the ***Plan Sponsor.***

Required Separation Between the Plan and the Plan Sponsor

1. This section describes the employees or classes of employees or workforce members under the control of

the ***Plan Sponsor*** who may be given access to individuals' PHI received from the ***Plan*** or from the ***claims processor*** servicing the ***Plan***: Insurance Manager

2. This list reflects the employees, classes of employees or other workforce members of the ***Plan Sponsor*** who receive individuals' PHI relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the ***Plan Sponsor*** provides for the ***Plan***. These individuals will have access to individuals' PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the ***Plan Sponsor***) for any use or disclosure of individuals' PHI in violation of, or noncompliance with, the provisions herein.

PRONOUNS

All personal pronouns used in this ***Plan*** shall include either gender unless the context clearly indicates to the contrary.

RECISSION OF COVERAGE

Notwithstanding the provisions for termination of coverage as provided within the section entitled, *Termination of Coverage,* or the retroactive termination of coverage as provided within the section entitled, *General Provisions, Misrepresentation,* should the ***Plan*** determine that a ***covered person's*** coverage hereunder should be terminated, the ***covered person's*** shall be sent a written notice of the effective date of termination of coverage to the last known address of the ***covered person***. Said notice shall be a minimum of thirty (30) calendar days prior to the effective date of termination.

RECOVERY FOR OVERPAYMENT

Whenever payments have been made from the ***Plan*** in excess of the maximum amount of payment necessary, the ***Plan*** will have the right to recover these excess payments. If the company makes any payment that, according to the terms of the ***Plan,*** should not have been made, the ***Plan*** may recover that incorrect payment, whether or not it was made due to the Company's own error, from the person or entity to whom it was made or from any other appropriate party.

SECURITY RULES

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the ***Plan Sponsor*** on behalf of the ***Plan,*** the ***Plan Sponsor*** shall reasonably safeguard the Electronic Protected Health Information as follows:

1. ***Plan Sponsor*** shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that ***Plan Sponsor*** creates, receives, maintains, or transmits on behalf of the ***Plan***;

2. ***Plan Sponsor*** shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

3. ***Plan Sponsor*** shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

4. ***Plan Sponsor*** shall report to the ***Plan*** any ***Security Incidents*** of which it becomes aware as described below:

    A. ***Plan Sponsor*** shall report to the ***Plan*** within a reasonable time after ***Plan Sponsor*** becomes aware, any ***Security Incident*** that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

B. ***Plan Sponsor*** shall report to the ***Plan*** any other ***Security Incident*** on an aggregate basis every quarter, or more frequently upon the ***Plan's*** request.

STATUS CHANGE

If an ***employee*** or ***dependent*** has a status change while covered under this ***Plan*** (i.e. ***dependent*** to ***employee,*** COBRA to Active) and no interruption in coverage has occurred, the ***Plan*** will provide continuance of coverage with respect to any ***preexisting condition*** limitation, deductible(s), ***coinsurance*** and ***maximum benefit.***

TIME EFFECTIVE

The effective time with respect to any dates used in the ***Plan*** shall be 12:00 a.m. (midnight) as may be legally in effect at the address of the ***Plan administrator.***

WORKERS' COMPENSATION NOT AFFECTED

This ***Plan*** is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.

DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in ***bold and italics*** throughout the document:

Administrative Period

The ***administrative period*** is the period of time used by the ***employer*** to assess an ***employee's*** eligibility for coverage under the ***Plan,*** prepare and distribute enrollment materials, and allow time for ***employee*** submission. The ***administrative period*** for new hire ***employees*** shall be two (2) ***calendar months*** starting with the calendar day after the last calendar day of a ***measurement period.*** The ***administrative period*** for ***ongoing employees*** shall be sixty (60) day period of time starting with the calendar day after the last calendar day of a ***measurement period.*** The ***administrative period*** for ***ongoing employees*** shall be two (2) ***calendar months*** of time starting with the calendar day after the last calendar day of a ***measurement period.***

Alternate Recipient

Any child of an ***employee*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan.***

Ambulatory Surgical Facility

A ***facility*** provider with an organized staff of ***physicians*** which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc. or by the ***Plan,*** which:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an ***outpatient*** basis;

2. Provides treatment by or under the supervision of ***physicians*** and nursing services whenever the ***covered person*** is in the ***ambulatory surgical facility;***

3. Does not provide ***inpatient*** accommodations; and

4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a ***physician.***

Approved Clinical Trials

A Phase 1, 2, 3 or 4clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and is one (1) of the following:

1. a federally funded or approved trial;

2. a clinical trial conducted under an FDA investigational new drug application;

3. a drug trial that is exempt from the requirement of an FDA investigational new drug application.

Benefit Year

The twelve-month period of January 1st through December 31st for which all ***Plan*** benefits shall be calculated. Any applicable deductible, out-of-pocket maximum expense limit, or ***maximum benefits*** shall accrue on a ***benefit year*** basis.

Birthing Center

A ***facility*** that meets professionally recognized standards and all of the following tests:

1. It mainly provides an ***outpatient*** setting for childbirth following a normal, uncomplicated ***pregnancy,*** in a home-like atmosphere.

2. It has: (a) at least two (2) delivery rooms; (b) all the medical equipment needed to support the services furnished by the facility; (c) laboratory diagnostic facilities; and (d) emergency equipment, trays, and supplies for use in life threatening situations.

3. It has a medical staff that: (a) is supervised full-time by a ***physician;*** and (b) includes a registered nurse at all times when ***covered persons*** are at the facility.

4. If it is not part of a ***hospital,*** it has written agreement(s) with a local ***hospital(s)*** and a local ambulance company for the immediate transfer of ***covered persons*** who develop complications or who require either pre or post-natal care.

5. It admits only ***covered persons*** who: (a) have undergone an educational program to prepare them for the birth; and (b) have medical records of adequate prenatal care.

6. It schedules ***confinements*** of not more than twenty-four (24) hours for a birth.

7. It maintains medical records for each ***covered person.***

8. It complies with all licensing and other legal requirements that apply.

9. It is not the office or clinic of one or more physicians or a specialized facility other than a birthing center.

Break in Service

A period of at least thirteen (13) consecutive ***weeks*** during which the ***employee*** has no ***hours of service*** for the ***employer.*** A ***break in service*** may also include any period for which the ***employee*** has no ***hours of service*** that is at least four (4) consecutive ***weeks*** in duration and longer than the prior period of employment as determined after application of the procedures applicable to ***special unpaid leaves***.

Calendar Month

One of the twelve (12) months named in the calendar (e.g. January, February, etc.).

Case Management

A program of medical management typically utilized in situations involving extensive and on-going medical treatment, which provides a comprehensive and coordinated delivery of services under the oversight of a medically responsible individual or agency. Such programs may provide benefits not normally covered under ***Plan*** provisions in lieu of ***inpatient hospital*** treatment.

Chemical Dependency

A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) criteria.

Chiropractic Care

Services as provided by a licensed Chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.

Claims Processor

The company contracted by the ***employer*** which is responsible for the processing of claims for benefits under the terms of the ***Plan*** and other ministerial services deemed necessary for the operation of the ***Plan*** as delegated by the ***employer.***

Close Relative

The ***employee's*** spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the ***employee's*** spouse.

Coinsurance

The benefit percentage of ***covered expenses*** payable by the ***Plan*** for benefits that are provided under the ***Plan.*** The ***coinsurance*** is applied to ***covered expenses*** after the deductible(s) have been met, if applicable.

Complications of Pregnancy

A disease, disorder or condition which is diagnosed as distinct from ***pregnancy,*** but is adversely affected by or caused by ***pregnancy.*** Some examples are:

1. Intra-abdominal surgery (but not elective Cesarean Section).

2. Ectopic ***pregnancy.***

3. Toxemia with convulsions (Eclampsia).

4. Pernicious vomiting (hyperemesis gravidarum).

5. Nephrosis.

6. Cardiac Decompensation.

7. Missed Abortion.

8. Miscarriage.

These conditions are not included: false labor; occasional spotting; rest during ***pregnancy*** even if prescribed by a ***physician;*** morning sickness; or like conditions that are not medically termed as ***complications of pregnancy.***

Concurrent Review

A review by the ***Utilization Review Organization*** which occurs during the ***covered person's hospital confinement*** to determine if continued ***inpatient*** care is ***medically necessary.***

Confinement

A continuous stay in a ***hospital, treatment center, extended care facility, hospice,*** or ***birthing center*** due to an ***illness*** or ***injury*** diagnosed by a ***physician.*** Later stays shall be deemed part of the original ***confinement*** unless there was either complete recovery during the interim from the ***illness*** or ***injury*** causing the initial stay, or unless the latter stay results from a cause or causes unrelated to the ***illness*** or ***injury*** causing the initial stay.

Copay

A cost sharing arrangement whereby a ***covered person*** pays a set dollar amount to a provider for a specific service at the time the service is provided.

Cosmetic Surgery, Cosmetic Treatment

Surgery or treatment for the restoration, repair, or reconstruction of body structures directed toward, or resulting in, improvement or preservation of physical appearance rather than to restore the anatomy and/or functions of the body which are lost or impaired due to an ***illness*** or ***injury***.

Covered Expenses

Medically necessary services, supplies or treatments that are recommended or provided by a ***physician, professional provider*** or covered ***facility*** for the treatment of an ***illness*** or ***injury*** and that are not specifically excluded from coverage herein. ***Covered expenses*** shall include specified preventive care services.

Covered Person

A person who is eligible for coverage under this ***Plan,*** or becomes eligible at a later date, and for whom the coverage provided by this ***Plan*** is in effect.

Custodial Care

Care provided primarily for maintenance of the ***covered person*** or which is designed essentially to assist the ***covered person*** in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an ***illness*** or ***injury.*** ***Custodial care*** includes, but is not limited to: help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services shall be considered ***custodial care*** without regard to the provider by whom or by which they are prescribed, recommended or performed.

Room and board and skilled nursing services are not, however, considered ***custodial care*** (1) if provided during ***confinement*** in an institution for which coverage is available under this ***Plan,*** and (2) if combined with other necessary therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the ***covered person's*** medical condition.

Customary and Reasonable Amount

Customary and reasonable amount shall mean ***covered expenses*** which are identified by the ***claims processor,*** taking into consideration the fee(s) which the provider of service most frequently charges the majority of patients for the service or supply; the amount the provider of service accepts from others as payment for the service or supply; the amount the provider of service accepts from others as payment for the service or supply; the cost to the provider of service for providing the service; the prevailing range of fees charged in the same "area" by providers of service of similar training and experience for the service or supply; and the ***Medicare*** reimbursement rates. The ***customary and reasonable amount*** shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross section of providers of service, persons or organizations rendering such treatment, services or supplies for which a specific charge is made.

Dentist

A licensed doctor of dental medicine (D.M.D.) or a licensed doctor of dental surgery (D.D.S.), other than a ***close relative*** of the ***covered person.***

Dependents

For a complete definition of ***dependent,*** refer to *Eligibility, Dependent Eligibility.*

Durable Medical Equipment

Medical equipment which:

1. Can withstand repeated use;

2. Is primarily and customarily used to serve a medical purpose;

3. Is generally not used in the absence of an ***illness*** or ***injury;***

4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered ***durable medical equipment. Durable medical equipment*** includes, but is not limited to: crutches, wheel chairs, ***hospital*** beds, etc.

Effective Date

The date of this ***Plan*** or the date on which the ***covered person's*** coverage commences, whichever occurs later.

Electronic Protected Health Information

The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

Emergency

A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in one or more of the following:

1. Placing the health of the ***covered person*** (or with respect to a pregnant woman, the health of the woman or her unborn fetus) in serious jeopardy, or

2. Serious impairment to bodily functions, or

3. Serious dysfunction of any bodily organ or part, or

With respect to a pregnant woman having contractions:

1. That there is inadequate time to effect a safe transfer to another hospital before delivery, or

2. That transfer may pose a threat to the health or safety of the woman or the unborn child.

Employee, or ***Regular Employee***

For a complete definition of employee, refer to *Eligibility, Employee Eligibility.* Such term shall not include individuals classified by the ***employer*** as independent contractors (including any person who later becomes reclassified as an ***employee*** by the Internal Revenue Service or a court of competent jurisdiction). For purposes of this document, any individual who pays or agrees to pay self-employment tax in lieu of withholding shall be deemed to be an independent contractor, not an ***employee.***

Employer

The ***employer*** is Blackwater Community School.

Enrollment Date

A ***covered person's enrollment date*** is the first day of any applicable service waiting period or the date of hire.

Experimental/Investigational

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

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. If the drug, device, medical treatment or procedure, or the ***covered person*** informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

3. If "reliable evidence" shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

"Reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Extended Care Facility

An institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an ***inpatient*** basis, for persons convalescing from ***illness*** or ***injury,*** professional nursing services, and physical restoration services to assist ***covered persons*** to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a registered nurse.

2. Its services are provided for compensation from its ***covered persons*** and under the full-time supervision of a ***physician*** or Registered Nurse.

3. It provides twenty-four (24) hour a day nursing services.

4. It maintains a complete medical record on each ***covered person.***

5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care, or a place for the care of ***mental and nervous disorders.***

6. It is approved and licensed by ***Medicare.***

This term shall also apply to expenses ***incurred*** in an institution referring to itself as a skilled nursing facility, convalescent nursing facility, or any such other similar designation.

Facility

A healthcare institution which meets all applicable state or local licensure requirements, such as a freestanding dialysis ***facility,*** a lithotriptor center or an outpatient imaging center.

Full-time

A common law ***employee*** who is regularly scheduled to work thirty (30) ***hours of service*** or more per week.

Generic Drug

A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or ***physician*** and must be clearly designated by the pharmacist or ***physician*** as generic.

Hours of Service

Each hour for which the ***employee*** is paid or entitled to payment for performance of services for the ***employer*** AND any hour for which the ***employee*** is paid or entitled to payment by the ***employer*** for a period of time during which no duties are performed due to any of the following:

- Vacation
- Holiday
- Illness or incapacity
- Layoff
- Jury duty
- Military duty or leave of absence

Home Health Aide Services

Those services which may be provided by a person, other than a Registered Nurse, which are ***medically necessary*** for the proper care and treatment of a person.

Home Health Care Agency

An agency or organization which meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.

2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one ***physician*** and at least one Registered Nurse. It must provide for full-time supervision of such services by a ***physician*** or Registered Nurse.

3. It maintains a complete medical record on each ***covered person.***

4. It has a full-time administrator.

5. It qualifies as a reimbursable service under ***Medicare.***

Hospice

An agency that provides counseling and medical services and may provide ***room and board*** to a terminally ill ***covered person*** and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.

2. It provides service twenty-four (24) hours per day, seven (7) days a week.

3. It is under the direct supervision of a ***physician.***

4. It has a Nurse coordinator who is a Registered Nurse.

5. It has a social service coordinator who is licensed.

6. It is an agency that has as its primary purpose the provision of ***hospice*** services.

7. It has a full-time administrator.

8. It maintains written records of services provided to the ***covered person.***

9. It is licensed, if licensing is required.

Hospital

An institution which meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to ***hospitals.***

2. It is engaged primarily in providing medical care and treatment to ***ill*** and ***injured*** persons on an ***inpatient*** basis at the ***covered person's*** expense.

3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an ***illness*** or ***injury;*** and such treatment is provided by or under the supervision of a ***physician*** with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.

4. It qualifies as a ***hospital*** and is accredited by The Joint Commission on the Accreditation of Healthcare Organizations.

5. It must be approved by ***Medicare.***

Under no circumstances will a ***hospital*** be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

Hospital shall include a facility designed exclusively for rehabilitative services where the ***covered person*** received treatment as a result of an ***illness*** or ***injury.***

The term ***hospital,*** when used in conjunction with ***inpatient confinement*** for mental and nervous conditions or ***chemical dependency,*** will be deemed to include an institution which is licensed as a mental ***hospital*** or ***chemical dependency*** rehabilitation and/or detoxification ***facility*** by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

Initial Measurement Period

The twelve (12) ***calendar month*** period beginning on the first day of the ***calendar month*** coinciding with or next following the ***employee's*** date of hire. Notwithstanding the foregoing, the ***employer*** may make adjustments to the ***standard measurement period*** with respect to ***employees*** on payroll periods that are weekly, bi-weekly or semi-monthly in duration.

Illness

A bodily disorder, disease, or physical sickness. ***Pregnancy*** of a covered ***employee*** or their covered spouse shall be considered an ***illness.***

Incurred or Incurred Date

With respect to a ***covered expense,*** the date the services, supplies or treatment are provided.

Injury

A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. ***Injury*** does not include ***illness*** or infection of a cut or wound, or self-inflicted ***injury.***

Inpatient

A ***confinement*** of a ***covered person*** in a ***hospital, hospice,*** or ***extended care facility*** as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for ***room and board.***

Intensive Care

A service which is reserved for critically and seriously ill ***covered persons*** requiring constant audio-visual surveillance which is prescribed by the attending ***physician.***

Intensive Care Unit

A separate, clearly designated service area which is maintained within a ***hospital*** solely for the provision of ***intensive care.*** It must meet the following conditions:

1. Facilities for special nursing care not available in regular rooms and wards of the ***hospital;***

2. Special life saving equipment which is immediately available at all times;

3. At least two beds for the accommodation of the critically ill; and

4. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours per day.

This term does not include care in a surgical recovery room.

Late Enrollee

A ***covered person*** who did not enroll in the ***Plan*** when first eligible or as the result of a Special Enrollment Period.

Layoff

A period of time during which the ***employee,*** at the ***employer's*** request, does not work for the ***employer,*** but which is of a stated or limited duration and after which time the ***employee*** is expected to return to ***full-time, active work.*** Layoffs will otherwise be in accordance with the ***employer's*** standard personnel practices and policies.

Life-threatening Condition

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Leave of Absence

A period of time during which the ***employee*** does not work, but which is of stated duration after which time the ***employee*** is expected to return to active work***.***

Maximum Benefit

Any one of the following, or any combination of the following:

1. The maximum amount paid by this ***Plan*** for any one ***covered person*** for a particular ***covered expense.*** The maximum amount can be for:

   A. The entire time the ***covered person*** is covered under this ***Plan,*** or
   B. A specified period of time, such as a ***benefit year***.

2. The maximum number the ***Plan*** acknowledges as a ***covered expense.*** The maximum number relates to the number of:

   A. Treatments during a specified period of time, or
   B. Days of ***confinement,*** or
   C. Visits by a ***home health care agency.***

Measurement Period

The ***initial measurement period*** or the ***standard measurement period***, as applicable to the Look Back ***measurement period*** method. For the monthly ***measurement period*** method, the ***calendar month.***

Medically Necessary (Medical Necessity)

Service, supply or treatment which, as determined by the ***employer/Plan administrator***, to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the ***covered person's illness*** or ***injury*** and which could not have been omitted without adversely affecting the ***covered person's*** condition or the quality of the care rendered;

2. In accordance with current standards of good medical practice within the organized medical community and is medically proven to be effective treatment of the ***illness*** or ***injury;***

3. The most appropriate supply or level of service that can safely be provided to the ***covered person.*** When applied to an ***inpatient*** admission, this further means that the ***covered person*** requires acute care as a bed patient due to the nature of the services rendered or the ***covered person's illness*** or ***injury,*** and the ***covered person*** cannot receive safe or adequate care as an ***outpatient.***

A service, supply, or treatment will not be considered ***medically necessary*** if:

1. It is provided only as a convenience to the ***covered person*** or provider;

2. It is part of a plan of treatment that is experimental, unproven, or related to research protocol.

The fact that a ***physician*** may prescribe, order, recommend, perform, or approve a service, supply or treatment does not, in and of itself, make the service, supply, or treatment ***medically necessary.*** In making the determination of whether a service or supply was ***medically necessary,*** the ***employer/Plan administrator***, or its designee, may request and rely upon the opinion of a ***physician*** or ***physicians.*** The determination of the ***employer/Plan administrator*** shall be final and binding.

Medicare

The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; and Part C, Miscellaneous provisions regarding both programs; and including any subsequent changes or additions to those programs.

Mental and Nervous Disorder

An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Month

The period that begins on any date following the first day of a ***calendar month*** and that ends on the immediately preceding date in the immediately following ***calendar month*** (for example, from February 2 to March 1 or from December 15 to January 14).

Negotiated Rate

The rate the ***preferred providers*** have contracted to accept as payment in full for ***covered expenses*** of the ***Plan.***

New Employee Stability Period

The twelve (12) ***calendar month*** period that begins on the first calendar day after the end of the ***administrative period,*** as it applies to the Look Back ***measurement period*** method.

Nonparticipating Pharmacy

Any pharmacy, including a ***hospital*** pharmacy, ***physician*** or other organization, licensed to dispense prescription drugs which does not fall within the definition of a ***participating pharmacy.***

Nonpreferred Provider

A ***physician, hospital,*** or other health care provider which does not have an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered.

Nurse

A licensed person holding the degree Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.) or Licensed Vocational Nurse (L.V.N.) who is practicing within the scope of the license.

Ongoing Employee

An ***employee*** who has been employed by the ***employer*** for at least one complete ***standard measurement period,*** as it applies to the Look Back ***measurement period*** method.

Ongoing Employee Stability Period

The twelve (12) ***calendar month*** period that begins on the first day of the ***calendar month*** following the end of the ***administrative period,*** as it applies to the Look Back ***measurement period*** method.

Outpatient

A ***covered person*** shall be considered to be an ***outpatient*** if he is treated at:

1. A ***hospital*** as other than an ***inpatient;***

2. A ***physician's*** office, laboratory or x-ray ***facility;*** or

3. An ***ambulatory surgical facility;*** and

The stay is less than twenty-three (23) consecutive hours.

Partial Confinement

A period of less than twenty-four (24) hours of active treatment in a ***facility*** licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services;

2. Treatment of ***mental and nervous disorders.***

3. Alcoholism treatment;

4. ***Chemical dependency*** treatment;

It may include day, early evening, evening, night care, or a combination of these four.

Participating Pharmacy

Any pharmacy licensed to dispense prescription drugs, which is contracted within the pharmacy organization.

Physician

A person duly licensed to practice medicine, to prescribe and administer drugs, or to perform surgery. This definition includes a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), Dentists, Podiatrists, Chiropractors, Psychologists and Psychiatrists provided that each, who is practicing within the scope of his license, is permitted to perform services covered under this ***Plan*** and that this ***Plan*** does not exclude the services provided by such ***physician.***

Placed For Adoption

The date the ***employee*** assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan

"Plan" refers to the benefits and provisions for payment of same as described herein.

Plan Administrator

The ***Plan administrator*** is responsible for the day-to-day functions and management of the ***Plan.*** The ***Plan administrator*** is the ***employer.***

Plan Documents

The ***Plan's*** governing document and instruments (i.e., the documents under which the group health plan was established and is maintained).

Plan Sponsor

The ***Plan sponsor*** is the ***employer.***

Preferred Provider

A ***physician, hospital*** or other health care ***facility*** who has an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered. ***Preferred providers*** agree to accept the ***negotiated rate*** as payment in full.

Preferred Provider Organization

An organization who selects and contracts with certain ***hospitals, physicians,*** and other health care providers to provide ***covered persons*** services, supplies and treatment at a ***negotiated rate.***

Pregnancy

The physical state which results in childbirth or miscarriage.

Primary Care Physician

General practitioner, family practice, internal medicine, OB/GYN, and pediatrician

Charges from Nurse Practitioners (N.P.) and Physician's Assistants (P.A.) will be considered at the level of the provider they bill under.

Professional Provider

A person or other entity licensed where required and performing services within the scope of such license. The covered ***professional providers*** include, but are not limited to:

Audiologist
Certified Addictions Counselor
Certified Registered Nurse Anesthetist
Certified Registered Nurse Practitioner
Chiropractor
Clinical Laboratory
Clinical Licensed Social Worker (A.C.S.W., L.C.S.W., M.S.W., R.C.S.W., M.A., M.E.D.)
Dietician
Dispensing optician
Midwife
Nurse (R.N., L.P.N., L.V.N.)
Occupational Therapist
Optician
Optometrist
Physical Therapist
Physician
Physician's Assistant
Podiatrist
Psychologist

Respiratory Therapist
Speech Therapist

Qualifying Part-time Employee

For a complete definition of ***qualifying part-time employee***, refer to the section entitled, *Eligibility, Employee Eligibility.*

Reconstructive Surgery

Surgical repair of abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.

Retrospective Review

A review by the ***Utilization Review Organization*** after the ***covered person's*** discharge from ***hospital confinement*** to determine if, and to what extent, ***inpatient*** care was ***medically necessary.***

Room and Board

Room and linen service, dietary service, including meals, ***medically necessary*** special diets and nourishments, and general nursing service. ***Room and board*** does not include personal items.

Seasonal Employee

An ***employee*** hired by the ***employer*** into a position that is expected to average thirty (30) hours or more per ***week***, but typically no longer in duration than six (6) months and begins at the same time of the year each year.

Semiprivate

The daily ***room and board*** charge which a ***facility*** applies to the greatest number of beds in its ***semiprivate*** rooms containing two (2) or more beds.

Security Incidents

The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system. For the purpose of the ***Plan Sponsor's*** requirement to report any ***Security Incidents***, only successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system shall be included.

Special Unpaid Leave of Absence

Any of the following types of unpaid leaves of absence that do not constitute a ***break in service***: (i) Leave protected by the Family and Medical Leave Act, (ii) leave protected by the Uniformed Services Employment and Reemployment Rights Act or (iii) Jury Duty (as reasonably defined by the ***employer***).

Standard Measurement Period

As it applies to the Look Back ***measurement period*** method, the twelve (12) ***month*** period that begins each May 1st and ends April 30th. Notwithstanding the foregoing, the ***employer*** may make adjustments to the ***standard measurement period*** with respect to ***employees*** on payroll periods that are weekly, bi-weekly or semi-monthly in duration.

Total Disability or Totally Disabled

The ***employee*** is prevented from engaging in his regular, customary occupation or from an occupation for which he or she becomes qualified by training or experience, and is performing no work of any kind for compensation or profit; or a ***dependent*** is prevented from engaging in all of the normal activities of a person of like age and sex who is in good health.

Treatment Center

1. An institution which does not qualify as a ***hospital,*** but which does provide a program of effective medical and therapeutic treatment for ***chemical dependency,*** and

2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or

3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:

    A. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
    B. It provides a program of treatment approved by the ***physician.***
    C. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the ***covered person.***
    D. It provides at least the following basic services:
        (1) ***Room and board***
        (2) Evaluation and diagnosis
        (3) Counseling
        (4) Referral and orientation to specialized community resources.

Urgent Care

A claims involving ***urgent care*** is generally a claim for medical care or treatment with respect to which the application of the time periods for making the non-urgent care determinations could seriously jeopardize the life or health of the ***covered person*** or the ability of the ***covered person*** to regain maximum function; or, in the opinion of the ***physician*** with knowledge of the ***covered person's*** medical condition, would subject the ***covered person*** to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Utilization Review

A process of evaluating if services, supplies or treatment are ***medically necessary*** to help ensure cost-effective care.

Utilization Review Organization

The individual or organization designated by the ***employer*** for the process of evaluating whether the service, supply, or treatment is ***medically necessary.***

Week

Any seven (7) consecutive ***calendar***-day period.

BLACKWATER COMMUNITY SCHOOL

EMPLOYEE BENEFIT PLAN

PPO PLAN OPTION

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

EFFECTIVE DATE: OCTOBER 1, 2015

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ADOPTION

Blackwater Community School has caused this Blackwater Community School Employee Benefit Plan PPO Plan Option ***(Plan)*** to take effect as of the first day of October 2015, at Coolidge, Arizona. I have read the document herein and certify the document reflects the terms and conditions of the employee welfare benefit plan as established by Blackwater Community School.

PLAN ADMINISTRATOR: BLACKWATER COMMUNITY SCHOOL

BY:_____ DATE:_____

SUMMARY PLAN DESCRIPTION

Name of Plan:

Blackwater Community School Employee Benefit Plan PPO Plan Option

Name, Address and Phone Number of Employer/Plan Sponsor:

Blackwater Community School
3652 E. Blackwater School Road
Coolidge, Arizona 85128
Phone: (520) 215-7910

Employer Identification Number:

74-2422892

Plan Number:

501

Type of Plan:

Group Health Plan providing coverage for: medical and prescription drug benefits

Type of Administration:

Contract administration: The processing of claims for benefits under the terms of the ***Plan,*** is provided through a company contracted by the ***employer*** and shall hereinafter be referred to as the ***claims processor.***

Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent for Service of Legal Process:

Blackwater Community School
3652 E. Blackwater School Road
Coolidge, Arizona 85128
Phone: (520) 215-7910

Eligibility Requirements:

For detailed information regarding a person's eligibility to participate in the ***Plan,*** refer to the following sections:

Eligibility
Enrollment
Effective Date of Coverage

Schedule of Benefits:

Eligible, enrolled ***employees*** and ***dependents*** are covered for the benefits under this ***Plan.*** Refer to the section entitled, *Schedule of Benefits.* The *Schedule of Benefits* will list all applicable ***maximum benefits;*** the extent to which preventive services are covered under the ***Plan;*** whether, and under what circumstances, existing and new drugs are covered under the ***Plan;*** whether, and under what circumstances, coverage is provided for medical tests, devices and procedures.

Procedures for Qualified Medical Child Support Orders:

Employees and ***dependents*** may obtain, without charge, a copy of the ***employer's*** procedures governing Qualified Medical Child Support Orders (QMCSO).

Employee/Dependent Contributions:

The amount of contributions paid for by the ***employer*** on behalf of the ***employee*** and the ***employee's dependents*** is determined by the ***employer.*** An ***employee*** may contact the ***employer*** for a current listing of the contribution schedule.

Employee/Dependent Cost Sharing:

All ***covered expenses*** are subject to applicable ***Plan*** provisions including, but not limited to: deductible, ***copay, coinsurance*** and ***maximum benefit*** provisions as shown in the *Schedule of Benefits*, unless otherwise indicated. Any expenses ***incurred*** by the ***covered person*** for services, supplies or treatment provided will not be considered ***covered expenses*** by this ***Plan*** if they are greater than the ***customary and reasonable amount*** for ***nonpreferred providers.***

Provider Network:

The ***Plan*** uses a ***Preferred Provider Organization***. A ***preferred provider*** is a ***physician, hospital*** or ancillary service provider which has an agreement in effect with the ***Preferred Provider Organization*** (PPO) to accept a reduced rate for services rendered to ***covered persons.*** This is known as the ***negotiated rate.*** The ***preferred provider*** cannot bill the ***covered person*** for any amount in excess of the ***negotiated rate. Covered persons*** should contact the Human Resources Department for a current listing of ***preferred providers.*** This PPO listing is provided at no charge.

Under the ***Plan, covered persons*** have the choice of using either a ***preferred provider*** or a ***nonpreferred provider.*** Because the ***covered person*** and the ***Plan*** save money when services, supplies or treatment are obtained from providers participating in the ***Preferred Provider Organization,*** benefits are usually greater than those available when using the services of a ***nonpreferred provider.*** Refer to the section entitled, *Schedule of Benefits.*

The sections entitled, *Schedule of Benefits* and *Preferred Provider or Nonpreferred Provider* will address provisions governing the use of ***preferred providers***, the composition of the provider network, and whether and under what circumstances coverage is provided for out-of-network services; any conditions or limits on the selection of a primary care provider or providers of specialty medical care; and any condition or limits applicable to obtaining emergency medical care.

Utilization Review (Precertification):

Utilization Review is the process of evaluating if services, supplies or treatment are ***medically necessary*** and appropriate to help ensure cost-effective care, also known as precertification. ***Utilization Review*** can eliminate unnecessary services, ***hospitalizations,*** and shorten ***confinements*** while improving quality of care and reducing costs to the ***covered person*** and the ***Plan.*** Certain procedures and/or treatments require precertification. Failure to comply with the precertification procedures may result in a reduction of benefits or loss of benefits. Refer to the sections entitled, *Schedule of Benefits* and *Utilization Review* for complete details.

Loss of Benefits:

For detailed information regarding a person being ineligible for benefits through reaching ***maximum benefit*** levels, reduction in benefits, or termination of coverage**,** refer to the following sections:

Schedule of Benefits
Utilization Review
Termination of Coverage
Plan Exclusions

Third Party Liability Reimbursement/Subrogation:

The ***Plan*** maintains the right to seek reimbursement on its own behalf: the right of subrogation. The ***Plan*** also reserves the right to reimbursement upon a ***covered person's*** (a covered ***employee*** or a covered dependent) receipt of settlement, judgment, or award: the right of reimbursement. The ***Plan*** reserves the right of recovery, either by subrogation or reimbursement, for ***covered expenses*** payable by the ***Plan*** which are a result of ***illness*** or ***injury***. The ***Plan*** shall be reimbursed from the first monies recovered as the result of judgment, settlement or otherwise. (This is known as "Pro tanto" subrogation.) This right includes the ***Plan's*** right to receive reimbursement from uninsured or underinsured motorist coverage and no-fault coverage.

Accepting benefits from this ***Plan*** automatically assigns to it any rights the ***covered person*** may have to recover benefits from any party, including an insurer or another group health program. This right of recovery allows the ***Plan*** to pursue any claim which the ***covered person*** may have against any party, group health program or insurer, whether or not the ***covered person*** chooses to pursue that claim. This includes a right to recover from no-fault auto insurance carriers in a situation where no third party may be liable, or from any uninsured or underinsured motorist coverage where the recovery was triggered by the actions of a party which caused or contributed to the payment of benefits under this ***Plan.*** This also includes a right to recover from amounts the ***covered person*** received from workers' compensation, whether by judgment or settlement, where the ***Plan*** has paid benefits prior to a determination that the medical expenses arose out of and in the course of employment. Payment by workers' compensation will be presumed to mean that such a determination has been made.

Failure to reimburse the ***Plan*** for ***covered expenses*** paid by the ***Plan*** that were also paid by a third party otherwise responsible shall result in a reduction of future claim benefits of a ***covered person*** up to the aggregate amount the ***Plan*** has paid.

For detailed information on the ***Plan's*** rights under third party liability reimbursement and/or subrogation, refer to the section entitled, *Third Party Liability Reimbursement/Subrogation.*

Plan Termination:

The ***employer*** reserves the right to terminate the ***Plan***, in whole or in part, at any time. Upon termination, the rights of the ***covered persons*** to benefits are limited to claims ***incurred*** up to the date of termination. Any termination of the ***Plan*** will be communicated to the ***covered persons.***

Upon termination of this ***Plan,*** all claims ***incurred*** prior to termination, but not submitted to either the ***employer*** or ***claims processor*** within three (3) months of the ***effective date*** of termination of this ***Plan,*** will be excluded from any benefit consideration.

The allocation and disposition of any assets of the ***Plan*** upon termination of the ***Plan*** shall include appropriate payment of ***Plan*** expenditures including administrative fees and ***covered expenses*** for ***covered persons***.

Plan Modification/Amendment:

The ***employer*** may modify or amend the ***Plan*** from time to time at its sole discretion, and such amendments or modifications which affect ***covered persons*** will be communicated to the ***covered persons*** within sixty (60) days after the adoption of the amendment***.*** Any such amendments shall be in writing, setting forth the modified provisions of the ***Plan,*** the ***effective date*** of the modifications, and shall be signed by the ***employer's*** designee. Such modification or amendment shall be duly incorporated in writing into the master copy of the ***Plan*** on file with the ***employer,*** or a written copy thereof shall be deposited with such master copy of the ***Plan.***

Continuation of Coverage (COBRA) Information:

Once coverage under the ***Plan*** becomes effective for ***employees*** and their ***dependents,*** those individuals have the right to continue coverage under the ***Plan*** should loss of coverage occur due to specified reasons. This period of continuation of coverage has specified time limitations, depending upon the reason for loss of coverage. ***Employees*** and ***dependents*** who elect continuation of coverage under this provision are responsible for payment of the full costs of

the ***Plan,*** including a two percent (2%) administration charge. For detailed information concerning continuation of coverage, refer to the section entitled, *Continuation of Coverage.*

Source of Plan Contributions:

Contributions for ***Plan*** expenses are obtained from the ***employer*** and from the covered ***employees*** for their covered ***dependents.*** The ***employer*** evaluates the costs of the ***Plan*** based on projected ***Plan*** expenses and determines the amount to be contributed by the ***employer*** and the amount to be contributed by the covered ***employees.***

Funding Method:

The ***employer*** pays ***Plan*** benefits and administration expenses directly from general assets. Contributions received from ***covered persons*** are used to cover ***Plan*** costs and are expended immediately.

Ending Date of Plan Year:

June 30th

Procedures for Filing Claims:

The following is intended to provide a general overview of the procedures for filing a claim, providing notice of benefit determinations, including "pre-service claims" known as ***Utilization Review (precertification)***, and appealing denied claims. For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled, *Claim Filing Procedures.* For detailed information on how to go through the ***Utilization Review*** process, or file an appeal on a decision from the ***Utilization Review Organization***, refer to the section entitled *Utilization Review.* The designated ***claims processor*** is: Summit Administration Services, Inc., P. O. Box 25160, Scottsdale, AZ 85255, 1-888-690-2020.

General Requirements:

1. The ***Plan*** may not have any provision that unduly inhibits or hampers claims filing or processing.

2. The ***Plan*** may not prohibit an authorized representative from acting on behalf of a ***covered person***.

3. The ***Plan*** must have administrative processes and safeguards to ensure that claim decisions are made based upon plan documents and have been consistently applied for similarly situated individuals.

4. Upon a ***covered person's*** request after a claim denial, the ***Plan*** must provide any relevant information verifying that it complied with its procedures.

Specific Requirements:

1. Claim Deficiencies

   A. Urgent Care Claims: If the claim is incomplete, the ***Plan*** must notify the ***covered person*** of the deficiency and specify what information is missing within seventy-two (72) hours after receipt of the claim. The ***covered person*** shall be afforded a reasonable amount of time, but no less than forty-eight (48) hours to provide the missing information. The ***Plan*** must then make the decision no more than forty-eight (48) hours after the earlier of: the ***Plan's*** receipt of the missing information or the end of the additional period of time.

   B. Pre-service Claims: In the event a ***covered person*** or his authorized representative submits a pre-service claim that does not comply with the ***Plan's*** claims procedures, within five (5) calendar days of the discovery of the defect, the ***Plan*** must provide the ***covered person*** or his representative with oral or written notice of the deficiency and the steps needed to cure it. If the

covered person or his representative requests such a notice to be in writing, the ***Plan*** must do so. The ***covered person*** shall have no less than forty-five (45) days to provide the information.

2. Timing of Notification of Benefit Determination The ***covered person*** shall be notified of the ***Plan's*** benefit determination on review as follows:

   A. Urgent Care Claims (precertification): If the ***physician*** classifies a claim as urgent, the ***Plan*** must recognize the claim as urgent. ***Covered persons*** must be notified of a benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after the receipt of the claim.

   B. Pre-service Claims: The ***Plan*** must make a benefit determination within fifteen (15) days after receipt of request from a ***covered person***. This time period may be extended for another fifteen (15) days if it is necessary because of matters beyond the ***Plan's*** control, and if the ***Plan*** notifies the ***covered person*** of those circumstances and the expected date of the decision before the end of the first fifteen (15) day period.

   C. Concurrent Care Claims: When a ***covered person*** requests extension of an on-going course of treatment beyond that which the ***Plan*** has approved, the ***Plan*** must make a decision regarding the extension within seventy-two (72) hours after receipt of the request and notify the ***covered person*** of the decision, provided the request for the extension was made at least seventy-two (72) hours before the end of the treatment which was already approved.

   D. Post-service Claims: The ***Plan*** shall notify the ***covered person*** of an adverse benefit determination not more than thirty (30) days after receipt of the claim by the ***Plan***. This time period may be extended for fifteen (15) days if it is necessary because of matters beyond the ***Plan's*** control, and if the ***Plan*** notifies the ***covered person*** of those circumstances and the expected date of decision before the end of the thirty (30) day period. This Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. The ***employee*** will be allowed up to forty-five (45) calendar days from receipt of the Notice of Extension to provide the additional information. The ***Plan*** will then make a claim determination within a reasonable period but not later than fifteen (15) calendar days from the date the ***Plan*** receives the additional information.

3. Appeals. The ***Plan*** may not require a ***covered person*** to file more than two (2) appeals before he is able to file a lawsuit.

   A. Urgent Care Claims (precertification): If certification of ***medical necessity*** is denied and the ***covered person*** appeals the denial, the ***Plan*** must render a review decision as soon as possible, but no more than seventy-two (72) hours after receiving the appeal.

   B. Pre-service Claims (precertification): If certification of ***medical necessity*** is denied and the ***covered person*** appeals the denial, the ***Plan*** must render a review decision within thirty (30) days after receiving the appeal. If the ***Plan*** provided for two (2) levels of review, both appeals must be decided within that thirty (30) day time period, and one must be decided within fifteen (15) days after receipt of the appeal. The ***covered person*** has 180 days to appeal a denial.

   C. Concurrent Care Claims: If the ***Plan*** has approved an on-going course of treatment, and then determines that such treatment should be reduced or terminated, the ***Plan*** must notify the ***covered person*** of this decision far enough in advance of the reduction or termination to allow the ***covered person*** to appeal the decision and obtain a review before the reduction or termination takes effect. This does not apply to an amendment or termination of the ***Plan.***

D. Post-service Claims: If a claim for benefits is denied by the ***Plan*** and the ***covered person*** appeals the denial, the ***Plan*** must render a review decision within sixty (60) days after receiving the appeal. If the ***Plan*** provides for two levels of review, both appeals must be decided within the sixty (60) day time period, and one must be decided within thirty (30) days following receipt of the appeal. The ***covered person*** has 180 days to appeal a claim denial.

Internal and External Appeal Process:

Refer to *Claim Filing Procedure, Internal and External Appeal Process* for more details.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act:

Under federal law, group health plans offering group health coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the ***Plan*** may pay for a short stay if the attending provider (e.g. the ***physician,*** nurse midwife, or physician assistant,) after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, group health plans may not set the level of benefits or 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 group health 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. However, to use certain providers or facilities, or to reduce the out-of-pocket cost, a ***covered person*** may be required to obtain precertification. For information on precertification, refer to the section entitled, *Utilization Review.*

Privacy Rights:

This ***Plan*** complies with the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). ***Covered Persons*** have the following rights under the HIPAA Privacy Rule:

1. The right to request restriction on the uses and disclosures of medical information. The ***employer*** is not required to agree to the requested restriction if the request is deemed unreasonable or would hinder the routine processing of claims.

2. The ***employer*** must give a ***covered person*** the opportunity to inspect or obtain copies of their medical information with exception for psychotherapy notes and information compiled for use in a civil, criminal or administrative action.

3. The ***employer*** must provide ***covered persons*** the opportunity to amend their medical information for as long as the ***employer*** maintains it for the ***Plan***. The ***employer*** may deny an individual's request for amendment if it determines that the medical information was not created by the ***Plan.***

SCHEDULE OF BENEFITS

The following *Schedule of Benefits* is designed as a quick reference. For complete provisions of the ***Plan's*** benefits, refer to the following sections: *Utilization Review, Preferred Provider Organization, Medical Expense Benefit, Prescription Drug Program* and *Plan Exclusions.*

A complete listing of ***preferred providers*** can be obtained from the Human Resources Department. Limitations are combined maximums for ***preferred*** and ***nonpreferred*** providers. Certain words and terms used herein are defined and are shown in ***bold and italics*** throughout the document. Refer to the section entitled, *Definitions.* All ***Plan*** benefits are calculated based on a "benefit year." The benefit year is January 1st through December 31st.

MEDICAL BENEFITS

Coinsurance:

After the individual or family deductible has been satisfied, the ***Plan*** pays the percentage listed on the following pages for ***covered expenses*** at the ***customary and reasonable amount*** for ***nonpreferred providers***, or the percentage of the ***negotiated rate*** for ***preferred providers***. This is known as the ***Plan's coinsurance.*** The ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the ***negotiated rate*** for ***preferred providers.*** For ***nonpreferred providers***, the ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the billed amount. The ***covered person's*** portion of the ***coinsurance*** represents the out-of-pocket expense limit.

For example, if the ***Plan*** pays seventy percent (70%) of the ***customary and reasonable amount*** for ***nonpreferred provider*** services, the ***covered person*** is responsible for the remaining thirty percent (30%) of the ***customary and reasonable amount.*** This thirty percent (30%) shall apply toward the out-of-pocket expense limit. However, any amount that the ***nonpreferred provider*** bills in excess of the ***customary and reasonable amount*** is not a ***covered expense*** of the ***Plan*** and does not apply toward the out-of-pocket expense limit. The ***covered person*** is responsible to pay any amount billed by a ***nonpreferred provider*** in excess of the ***customary and reasonable amount.***

Once the out-of-pocket expense limit has been reached, the ***Plan*** pays one hundred percent (100%) of ***incurred covered expenses*** for the remainder of the ***benefit year***. Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit,* for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance.***

BENEFIT DESCRIPTION & BENEFIT LIMITATION The ***benefit year*** is January 1st through December 31st.	PREFERRED PROVIDER After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***negotiated rate.***	NONPREFERRED PROVIDER After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***customary and reasonable amount.***

Precertification Penalty Failure to obtain precertification for services requiring precertification shall result in a $300 penalty deductible applying to ***covered expenses*** first, then any applicable ***benefit year*** deductible, then the ***Plan's coinsurance*** applies. No benefits payable for transplants without precertification.		
Benefit Year **Deductible** Individual (Per Person) Family (Aggregate)	 $2,000 $4,000	 $4,000 $8,000
Out-of-Pocket Expense Limit Per *Benefit Year*: (includes medical and prescription ***copays*** and ***coinsurance*****)** Individual Family (Aggregate) Refer to *Medical Expense Benefit,* ***Benefit Year*** *Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit.	 $6,000 $12,000	 $8,000 $16,000
Inpatient Hospital Precertification required.	80%	50%
Outpatient Hospital/Ambulatory Surgical Facility Specified procedures require precertification. See *Utilization Review.*	80%	50%
Ambulance Service	80% after ***PPO*** deductible	20% after ***PPO*** deductible.
Emergency Room Services	80% after ***PPO*** deductible	20% after ***PPO*** deductible
Physician's Services Home, Inpatient, Office Visit Surgery - Physician's Office Surgery - Other Pathology Anesthesiology Radiology	 80% 80% 80% 80% 80% 80%	 50% 50% 50% 50% 50% 50%
Extended Care Facility Precertification required. Limitation: 90 days ***maximum benefit*** per ***benefit year***	80%	50%
Home Health Care Precertification required.	80%	50%
Hospice Care Precertification required.	80%	50%
Durable Medical Equipment	80%	50%
Preventive Care Services All preventive care services as recommended by the U.S. Preventive Services Task Force	100%; deductible waived For a complete listing, go to: www.healthcare.gov/coverage/preventive-care-benefits	Not Covered

BENEFIT DESCRIPTION & BENEFIT LIMITATION The ***benefit year*** is January 1st through December 31st.	PREFERRED PROVIDER After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***negotiated rate.***	NONPREFERRED PROVIDER After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***customary and reasonable amount.***

Pediatric Health Care	100%; deductible waived	Not Covered
	For a complete listing, go to: www.healthcare.gov/coverage/preventive-care-benefits	
Immunizations	100%. deductible waived	Not Covered
	For a complete listing, go to: www.healthcare.gov/coverage/preventive-care-benefits	
Preventive Care: Well Woman Preventive Services Includes: Well Woman Visits; Screening for gestational diabetes; Human Papillomavirus testing; counseling for sexually transmitted infections; counseling & screening for human immune-deficiency virus; contraceptive methods & counseling; breast-feeding support, supplies and counseling; screening & counseling for interpersonal & domestic violence;	100%; deductible waived	Not Covered
	For a complete listing, go to: www.healthcare.gov/coverage/preventive-care-benefits	
Routine Mammogram	100%: deductible waived	50%: deductible waived
Mental & Nervous Disorders/Chemical Dependency ***Inpatient*** Services Precertification required	80%	50%
Outpatient Services	80%	50%
Therapy Services (Radiology, Chemotherapy, Dialysis)	80%	50%
Rehabilitative Services (Physical, Speech, Occupational) Limited to 20 visits per ***benefit year*** for ***outpatient*** physical and occupational therapy combined Limited to 20 visits per ***benefit year*** for ***outpatient*** speech therapy Additional benefits for services of a ***preferred provider*** that exceed the annual maximum may be available if determined to be ***medically necessary*** by the ***Utilization Review Organization.*** Such benefits shall be payable at 50% up to a maximum out-of-pocket expense of $500. After the maximum out-of-pocket has been reached, benefits shall be payable at 100%.	80%; deductible waived The deductible is not waived for evaluations prior to therapy.	50%; deductible waived The deductible is not waived for evaluations prior to therapy.
Chiropractic Care Limitation: 20 visits ***maximum benefit*** per ***benefit year***	80%	50%

BENEFIT DESCRIPTION & BENEFIT LIMITATION The ***benefit year*** is January 1st through December 31st.	PREFERRED PROVIDER After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***negotiated rate.***	NONPREFERRED PROVIDER After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***customary and reasonable amount***
Prosthetics	80%	50%
Dental Injury	80%	80%
Transplants **Limited to $200 per day/$10,000 while covered by this Plan for travel and lodging with no deductible or coinsurance**	80%	50%
Temporomandibular Joint Dysfunction Limited to $1,000 ***maximum benefit*** while covered by this ***Plan***.	80%	50%
Diagnostic Testing, Lab and X-ray Services	80%	50%
Neuropsychological and Cognitive Testing Limited to 10 hours of testing per calendar year	80%	50%
Cataract Surgery Limited to $500 ***maximum benefit*** for initial pair of eyeglasses or contacts following surgery	80%	50%
Hearing Services and Devices Limited to $25,000 while covered by this ***Plan.***	80%	50%
All Other Covered Expenses	80%	50%

PRESCRIPTION DRUG PROGRAM

POINT OF PURCHASE	BENEFIT	SUPPLY LIMITATION
Participating Pharmacy	100% ***Plan*** payment after ***copay****:* Contraceptives & other non-prescription drugs as mandated by the Patient Protection and Affordable Care Act: $0 ***copay*** Generic & Diabetic Supplies & Drugs: $5 ***copay*** Formulary Brand Name: $25 ***copay*** Non-Formulary Brand Name: $75 ***copay*** Specialty Drugs: $200 ***copay***	30 day supply
Nonparticipating Pharmacy	Not Covered	
Mail Order	Contraceptives & other non-prescription drugs as mandated by the Patient Protection and Affordable Care Act: $0 ***copay*** Generic & Diabetic Supplies & Drugs: $5 ***copay*** Formulary Brand Name: $25 ***copay*** Non-Formulary Brand Name: $75 ***copay*** Specialty Drugs: $200 ***copay***	90 day supply
Out-of-Pocket Expense Limit	The ***copays*** under the *Prescription Drug Program* shall apply toward the *Medical Expense Benefit,* ***preferred provider*** Out-of-Pocket Expense Limit. Refer to Out-of-Pocket Expense Limit Exclusions for a listing of charges not applicable.	

UTILIZATION REVIEW

Utilization review is the process of evaluating if services, supplies or treatment are ***medically necessary*** and appropriate to help ensure cost-effective care. ***Utilization Review*** can eliminate unnecessary services, ***hospitalizations,*** and shorten ***confinements*** while improving quality of care and reducing costs to the ***covered person*** and the ***Plan.***

Certification of ***medical necessity*** and appropriateness by the ***Utilization Review Organization*** does not establish eligibility under the ***Plan*** nor guarantee benefits.

PRECERTIFICATION

Hospital/Outpatient Surgery

All medical, surgical, psychiatric, substance abuse ***hospital*** admissions, including acute ***hospital*** admissions long term acute admissions. Acute rehabilitation, acute detoxification and specified ***outpatient hospital/ambulatory surgical facility*** procedures are to be certified in advance of the proposed ***confinement*** or surgery (precertification) by the ***Utilization Review Organization,*** except for ***emergencies***. The ***covered person*** or their representative should call the ***Utilization Review Organization*** prior to admission. ***Emergency hospital*** admissions are to be reported to the ***Utilization Review Organization*** within forty-eight (48) hours following admission, or on the next business day after admission.

Covered persons should contact the Utilization Review Organization by calling: 1-800-944-9401

Group health plans generally may not, under federal law, restrict benefits for any ***hospital*** length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. If delivery occurs in the ***hospital,*** the 48-hour period, or 96-hours, begins at the time of delivery. If delivery occurs outside the ***hospital*** and is later ***confined*** to the ***hospital*** in connection with childbirth, the period begins at the time of the ***hospital*** admission. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law require that a provider obtain authorization from the ***Plan*** for prescribing a length of stay not in excess of the above periods. If a newborn remains hospitalized beyond the time frames specified above, the ***confinement*** must be precertified.

After admission to the ***hospital,*** the ***Utilization Review Organization*** will continue to evaluate the ***covered person's*** progress through ***concurrent review*** to monitor the length of ***confinement*** and ***medical necessity*** of treatment. If the ***Utilization Review Organization*** disagrees with the length of ***confinement*** recommended by the ***physician,*** the ***covered person*** and the ***physician*** will be advised. If the ***Utilization Review Organization*** determines that continued ***confinement*** is no longer necessary, additional days will not be certified. **Benefits payable for days not certified as *medically necessary* by the *Utilization Review Organization* shall be denied.**

However, in the event that a ***retrospective review***, (a review completed after the event), determines that the hospitalization or surgery did not exceed the amount that would have been approved had the precertification been completed, there will be no penalty assessed and the amount of any deductible and/or ***coinsurance*** will count towards the satisfaction of the ***covered person's*** maximum out-of-pocket expense.

PRECERTIFICATION PENALTY

For the purpose of determining benefits payable if certification of ***medical necessity*** is not obtained, ***covered expenses*** shall be subject to a three hundred dollar ($300) penalty deductible applying to ***covered expenses*** first, then any applicable ***benefit year*** deductible, then the ***Plan's coinsurance*** applies. In addition no benefits shall be payable for transplants if precertification is not obtained.

NOTIFICATION DEFICIENCIES

Urgent Care Claims: If the request for precertification is incomplete, the ***Utilization Review Organization*** must notify the ***covered person*** of the deficiency and specify what information is missing within seventy-two (72) hours after receipt of the claim. The ***covered person*** shall be afforded a reasonable amount of time, but no less than forty-eight (48) hours to provide the missing information. The ***Plan*** must then make the decision no more than forty-eight (48) hours after the earlier of: the ***Plan's*** receipt of the missing information or the end of the additional period of time.

Pre-service Claims: In the event a ***covered person*** or his authorized representative submit a pre-service claim that does not comply with the ***Plan's*** claims procedures, within five (5) calendar days of the discovery of the defect, the ***Plan*** must provide the ***covered person*** or his representative with oral or written notice of the deficiency and the steps needed to cure it. If the ***covered person*** or his representative requests such a notice to be in writing, the ***Plan*** must do so. The ***covered person*** shall have no less than forty-five (45) days to provide the information.

TIMING OF NOTIFICATION

The ***covered person*** shall be notified of the ***Plan's*** benefit determination on review as follows:

Urgent Care Claims (precertification): If the ***physician*** classifies a claim as urgent, the ***Plan*** must recognize the claim as urgent. ***Covered persons*** must be notified of decisions as soon as possible, but no more than seventy-two (72) hours after receipt of the claim.

Pre-service Claims: The ***Plan*** must make a benefit determination within fifteen (15) days after receipt of request from a ***covered person***. This time period may be extended for another fifteen (15) days if it is necessary because of matters beyond the ***Plan's*** control, and if the ***Plan*** notifies the ***covered person*** of those circumstances and the expected date of the decision before the end of the first fifteen (15) day period.

Concurrent Care Claims: When a ***covered person*** requests extension of an on-going course of treatment beyond that which the ***Plan*** has approved, the ***Plan*** must make a decision regarding the extension within twenty-four (24) hours after receipt of the request and notify the ***covered person*** of the decision, provided the request for the extension was made at least twenty-four (24) hours before the end of the treatment which was already approved.

PRECERTIFICATION APPEAL PROCESS

In the event certification of ***medical necessity*** is denied by the ***Utilization Review Organization,*** the ***covered person*** may appeal the decision. The ***covered person*** may call the ***Utilization Review Organization*** for more information concerning the appeal process.

Urgent Care Claims (precertification): If certification of ***medical necessity*** is denied and the ***covered person*** appeals the denial, the ***Utilization Review Organization*** must render a review decision as soon as possible, but no more than seventy-two (72) hours after receiving the appeal.

Pre-service Claims (precertification): If certification of ***medical necessity*** is denied and the ***covered person*** appeals the denial, the ***Utilization Review Organization*** must render a review decision within thirty (30) days after receiving the appeal. If two (2) levels of review are provided, both appeals must be decided within that thirty (30) day time period, and one must be decided within fifteen (15) days after receipt of the appeal. The ***covered person*** has 180 days to appeal a denial.

Concurrent Care Claims: If the ***Utilization Review Organization*** has approved an on-going course of treatment, and then determines that such treatment should be reduced or terminated, the ***Utilization Review Organization*** must notify the ***covered person*** of this decision far enough in advance of the reduction or termination to allow the ***covered person*** to appeal the decision and obtain a review before the reduction or termination takes effect. This does not apply to an amendment or termination of the ***Plan.***

CASE MANAGEMENT

In cases where the ***covered person's*** condition is expected to be or is of a serious nature, the ***Utilization Review Organization*** may arrange for review and/or ***Case Management*** services from a professional qualified to perform such services. The ***employer*** shall have the right to alter or waive the normal provisions of this ***Plan*** when it is reasonable to expect a cost effective result without a sacrifice to the quality of care.

Case Management will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that ***covered person*** or any other ***covered person.***

ALTERNATIVE CARE

The ***Utilization Review Organization*** may recommend (or change) alternative methods of medical care or treatment, equipment or supplies that are not ***covered expenses*** under this ***Plan;*** or are ***covered expenses*** under this ***Plan*** but on a basis that differs from the alternative recommended by the ***Utilization Review Organization.*** The ***Plan*** will recognize such alternative services as ***covered expenses.***

Alternative care will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that ***covered person*** or any other ***covered person.***

PREFERRED PROVIDER OR NONPREFERRED PROVIDER

Covered persons have the choice of using either a ***preferred provider*** or a ***nonpreferred provider.***

PREFERRED PROVIDERS

A ***preferred provider*** is a ***physician, hospital*** or ancillary service provider which has an agreement in effect with the ***Preferred Provider Organization*** (PPO) to accept a reduced rate for services rendered to ***covered persons.*** This is known as the ***negotiated rate.*** The ***preferred provider*** cannot bill the ***covered person*** for any amount in excess of the ***negotiated rate.*** Because the ***covered person*** and the ***Plan*** save money when services, supplies or treatment are obtained from providers participating in the ***Preferred Provider Organization,*** benefits are usually greater than those available when using the services of a ***nonpreferred provider. Covered persons*** should contact the Human Resources Department for a current listing of ***preferred providers.***

Advantages of Using a Preferred Provider

1. The ***covered person*** is not billed for charges that exceed the ***negotiated rate.***

2. The ***covered person*** saves money on health care costs because (A) of the reduced rate (***negotiated rate***) and, (B) the ***Plan*** is able to provide greater benefits from ***preferred providers***.

How to Use the Preferred Providers

1. When the ***covered person*** needs to see the ***physician*** or other health care provider, the directory of ***preferred providers*** will supply a listing of providers in the area. The ***covered person*** should contact the provider to verify the provider is still a member of the ***Preferred Provider Organization.*** It is possible that some providers may have been added to or deleted from the ***Preferred Provider Organization.*** If the provider is still a member, an appointment can be scheduled.

2. Upon arrival for the scheduled appointment, the ***covered person*** should show the ***participating provider*** the identification card. The ***participating provider's*** billing office will submit the claim on behalf of the ***covered person*** to the ***claims administrator***.

3. If additional services from other providers are required, such as diagnostic x-ray and laboratory, the ***covered person*** should ask the ***participating provider*** to ensure such other provider is also a ***participating provider.***

MEDICARE-LIKE RATE PRICING

As permitted under C.F.R. Title 42, Part 136, Subpart D, benefits payable for ***covered expenses*** for ***inpatient*** and ***outpatient hospital*** services which qualify as expenses under the ***Medicare***-Like Rate Program shall be processed at the ***Medicare***-Like Rate pricing or the ***preferred provider negotiated rate,*** whichever is less.

NONPREFERRED PROVIDERS

A ***nonpreferred provider*** does not have an agreement in effect with the ***Preferred Provider Organization.*** This ***Plan*** will allow only the ***customary and reasonable amount*** as a ***covered expense.*** The ***Plan*** will pay its percentage of the ***customary and reasonable amount*** for the ***nonpreferred provider*** services, supplies and treatment. The ***covered person*** is responsible for the remaining balance. This results in greater out-of-pocket expenses to the ***covered person.***

In the event the total charges by a ***nonpreferred provider*** are less than the ***preferred provider negotiated rate,*** or if the ***nonpreferred provider*** agrees to accept less or the equivalent of the ***preferred provider negotiated rate,*** the ***claims***

processor may, in its discretion on behalf of the ***Plan,*** pay the ***nonpreferred provider*** at the ***preferred provider*** level of benefits identified in the section entitled *Schedule of Benefits.*

REFERRALS

Referrals to a ***nonpreferred provider*** are covered as ***nonpreferred provider*** services, supplies and treatments. It is the responsibility of the ***covered person*** to ensure services to be rendered are performed by ***preferred providers*** in order to receive the ***preferred provider*** level of benefits.

EXCEPTIONS

The following listing of exceptions represents services, supplies or treatments rendered by a ***nonpreferred provider*** where ***covered expenses*** shall be payable at the ***preferred provider*** level of benefits:

1. Radiologist or pathologist services for interpretation of x-rays and laboratory tests rendered by a ***nonpreferred provider*** when the ***facility*** rendering such services is a ***preferred provider.***

2. While confined to a ***preferred provider hospital,*** the ***preferred provider physician*** requests a consultation from a ***nonpreferred provider.***

3. ***Nonpreferred*** anesthesiologist if the operating surgeon is a ***preferred provider.***

4. Diagnostic laboratory and pathology tests referred to a ***nonpreferred provider*** by a ***preferred provider.***

5. If a ***covered person*** is out of the EPO/PPO service are and has a medical ***emergency*** requiring immediate care, including related services such as ancillary providers.

6. ***Medically necessary*** services, supplies and treatments not available through any ***preferred provider.***

MEDICAL EXPENSE BENEFIT

This section describes the ***covered expenses*** of the ***Plan.*** All ***covered expenses*** are subject to applicable ***Plan*** provisions including, but not limited to: deductible, ***copay, coinsurance*** and ***maximum benefit*** provisions as shown in the *Schedule of Benefits*, unless otherwise indicated. Any expenses ***incurred*** by the ***covered person*** for services, supplies or treatment provided will not be considered ***covered expenses*** by this ***Plan*** if they are greater than the ***customary and reasonable amount*** or ***negotiated rate,*** as applicable**.** The ***covered expenses*** for services, supplies or treatment provided must be recommended by a ***physician*** or ***professional provider*** and be ***medically necessary*** care and treatment for the ***illness*** or ***injury*** suffered by the ***covered person.*** Specified preventive care expenses will be covered by this ***Plan.***

COPAY

The ***copay*** is the amount payable by the ***covered person*** for certain services, supplies or treatment**.** The service and applicable ***copay*** are shown on the *Schedule of Benefits.* The ***copay*** must be paid each time a treatment or service is rendered. The ***copay*** will not be applied toward the ***benefit year*** deductible.

DEDUCTIBLES

Preferred Provider Incentive

As an added incentive to utilize ***preferred providers,*** the ***covered person's benefit year*** deductible is less for ***preferred providers*** than the ***benefit year*** deductible of ***nonpreferred providers.*** The individual ***benefit year*** deductible is combined between ***preferred*** and ***nonpreferred providers,*** until the ***preferred provider benefit year*** deductible has been reached. Any additional ***covered expenses*** rendered by a ***nonpreferred provider*** shall be subject to the balance of the ***nonpreferred provider benefit year*** deductible as shown on the *Schedule of Benefits.*

Individual Deductible

The individual deductible is the dollar amount of ***covered expense*** which each ***covered person*** must have ***incurred*** during each ***benefit year*** before the ***Plan*** pays applicable benefits. The individual deductible amount is shown on the *Schedule of Benefits.*

Family Deductible

If in any ***benefit year*** covered members of a family incur ***covered expenses*** that are subject to the deductible which are equal to or greater than the dollar amount of the family deductible shown on the *Schedule of Benefits,* the family deductible will be considered satisfied for all family members for that ***benefit year***. Any number of family members may help to meet the family deductible amount, but no more than each person's individual deductible amount may be applied toward satisfaction of the family deductible by any family member.

COINSURANCE

The ***Plan*** pays a specified percentage of ***covered expenses*** at the ***customary and reasonable amount*** for ***nonpreferred providers***, or the percentage of the ***negotiated rate*** for ***preferred providers***. That percentage is specified in the *Schedule of Benefits*. The ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the ***negotiated rate*** for ***preferred providers.*** For ***nonpreferred providers***, the ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the billed amount.

BENEFIT YEAR OUT-OF-POCKET EXPENSE LIMIT

Preferred Provider Incentive

As an added incentive to utilize ***preferred providers,*** the ***covered person's*** out-of-pocket expense limit is less for ***preferred providers*** than the out-of-pocket expense limit of ***nonpreferred providers.*** The individual ***benefit year*** out-of-pocket expense limit is combined between ***preferred*** and ***nonpreferred providers,*** until the ***preferred provider*** out-of-pocket expense limit has been reached. Any additional ***covered expenses*** rendered by a ***nonpreferred provider*** shall be subject to the balance of the ***nonpreferred provider benefit year*** out-of-pocket expense limit as shown on the *Schedule of Benefits.*

Individual *Benefit Year* Out-of-Pocket Expense Limit

After the ***covered person*** has incurred an amount equal to the out-of-pocket expense limit listed on the *Schedule of Benefits* for ***covered expenses,*** including ***copays***, the ***Plan*** will begin to pay one hundred percent (100%) for ***covered expenses*** for the remainder of the ***benefit year***.

Family *Benefit Year* Out-of-Pocket Expense Limit

After a covered family has incurred an combined amount equal to the family out-of-pocket expense limit listed on the *Schedule of Benefits* for ***covered expenses,*** including ***copays***, the ***Plan*** will begin to pay one hundred percent (100%) for ***covered expenses*** for all covered family members for the remainder of the ***benefit year***.

Out-of-Pocket Expense Limit Exclusions

The following items do not apply toward satisfaction of the ***benefit year*** out-of-pocket expense limit:

1. Expenses for services, supplies and treatments not covered by this ***Plan,*** to include charges in excess of the ***customary and reasonable amount.***

2. Expense ***incurred*** as a result of failure to obtain precertification.

MAXIMUM BENEFIT

The *Schedule of Benefits* contains separate ***maximum benefit*** limitations for specified conditions. Any separate ***maximum benefit*** will include all such benefits paid by the ***Plan*** for the ***covered person*** during any and all periods of coverage under this ***Plan.***

COVERED EXPENSES

AMBULANCE SERVICES

Ambulance services must be by a licensed air or ground ambulance. ***Covered expenses*** shall include:

1. Ambulance services for air or ground transportation for the ***covered person*** from the place of ***injury*** or serious medical incident to the nearest ***hospital*** where treatment can be given.

2. Ambulance service is covered in a non-emergency situation only to transport the ***covered person*** to or from a ***hospital*** or between ***hospitals*** for required treatment when such treatment is certified by the attending ***physician*** as ***medically necessary.*** Such transportation is covered only from the initial ***hospital*** to the nearest ***hospital*** qualified to render the special treatment.

3. ***Emergency*** services actually provided by an advance life support unit, even though the unit does not provide transportation.

B-12 INJECTIONS

Covered expenses shall include charges for B-12 injections when there is documented deficiency related to malabsorption or impaired utilization and unresolved with oral Vitamin B-12. B-12 therapy is reasonable and necessary when pathologic conditions preclude adequate B-12 absorption from food.

B-12 injections are ***medically necessary*** only for ***covered persons*** with any one of the following diagnoses and conditions:

a. Anemia
- Pernicious anemia (Addision anemia, Biermer's anemia)
- Macrocytic anemia
- Fish tapeworm anemia
- Megaloblastic anemia

b. Gastrointestinal disorders
- Malasorption syndromes such as sprue
- Idiopathic steatorrhea
- Other malabsorption
- Surgical or mechanical disorders such as:
  - resection of the small intestine
  - intestinal strictures
  - intestinal anastomosis
  - blind loop syndrome
  - gastrectomy (subtotal or total)

c. Neuropathy
- Posterolateral sclerosis
- Neuropathies associated with pernicious anemia (Addison anemia, Biermer's anemia)
- Acute phase or acute exacerbation of a neuropathy due to malnutrition or alcoholism

d. Methylamalonic aciduria

e. Homocystinuria

f. Retrobulbar neuritis associated with heavy smoking, also known as tobacco amblyopia

g. Dementia secondary to Vitamin B12 deficiency

h. ***Covered persons*** receiving pemetrexed (Alimta) (see CPB 687)

Physician administration of Vitamin B-12 injections is considered ***medically necessary*** for the diagnoses and conditions listed above.

Administration of Vitamin B-12 injections for more than two (2) to three (3) is subject to review to ascertain if deficiency/abnormalities have improved and to decide whether continued treatment is ***medically necessary.***

Measurement of serum homocystine is considered ***medically*** in persons with borderline B-12 deficiency, where the results will impact the patients management.

BARIATRIC SURGERY

Covered expenses shall include bariatric surgery (restrictive gastrointestinal surgery, adjustable gastric band system sleeve procedures and any other FDA-approved procedure). Such services shall be processed based on clinical criteria and will be considered ***medically necessary*** with documentation of all of the following:

a. The individual is morbidly obese as defined by one (1) of the following:
   - Body Mass Index (BMI) of forty (40) or greater
   - Body Mass Index (BMI) of fifty (50) or greater for biliopancreatic diversion with duodenal switch Procedure
   - Body Index of thirty-five (35) or greater with any of the following co-morbid conditions that are generally expected to be ameliorated (improved), reversed, or limited by this surgical treatment, for any eligible procedure.

b. Co-morbid conditions include, but are not limited to:
   - Cardiovascular disease
   - Coronary disease
   - Degenerative joint disease of weight bearing points
   - Diabetes mellitus
   - Documented sleep apnea
   - Pseudotumor cerebri
   - Pulmonary hypoventilation

c. Diagnosis of morbid obesity for five (5) years or more

d. Continuous participation in a ***physician-***supervised OR structures weight-loss program(s) for six (6) months or longer with a completion date in the preceding year as documented by the following:
   - Weight-loss program(s) in which the individual has participated reflects continuous involvement for a total of six (6) months, or longer and
   - Weight-loss program(s) is a ***physician-***supervised program or a structured weight-loss program (program must be identified and dates of participation must be outlined), and
   - Weight-loss program(s) include a diet and exercise program and/or pharmacological therapy.

e. Failure of non-surgical methods of weight loss as documented by the following:
   - Length of time individual was enrolled or participated in the weight-loss program(s) (program must be identified and dates of participation must be outlined), and
   - Regular follow-up visits documenting program (weekly, monthly) and
   - Results achieved, e.g. weight loss and time to regain the lost weight

f. Pre-operative clinical assessment and documentation must reflect a significant motivation and understanding of the risks associated with the intended surgery, as well as an understanding of the life-long restricted eating habits that will follow.

g. Clinical documentation must reflect a plan for active participation in both a pre-surgical instruction program and a post-surgical, post-operative or follow-up program. Clinical documentation must reflect participation in pre-operative nutritional counseling and that there is a plan in place for post-operative nutritional counseling as well.

h. Individual is eighteen (18) years of age or older.

i. Individual has no treatable condition that may be responsible for the morbid obesity; e.g. endocrine, metabolic, etc.

j. Individual has no significant liver, kidney or gastrointestinal disease.

k. Individual has no drug or alcohol abuse – must be abstinent for twelve (12) months or more if there is a history of drug or alcohol abuse.

l. Individual has no contraindications to surgery.

m. Individual has had an evaluation by a licensed psychologist or psychiatrist documenting the absence of significant psychopathology that may limit an individual's understanding of the procedure or ability to comply with medical/surgical recommendations (e.g. active ***chemical dependency,*** schizophrenia, borderline personality disorder, uncontrolled depression). Clinical documentation must substantiate approval by the attending clinician for the intended procedure if the individual has current symptoms of or is on maintenance for psychological or psychiatric disease.

n. Post-surgery follow-up office visits, related to the approved surgical procedure and outside of the global follow-up period are ***covered expenses,*** subject to the deductible, ***coinsurance*** or ***copay*** provisions.

Repeat bariatric surgeries shall be covered if current ***Plan*** guidelines for bariatric surgery are met.

Revisions to an eligible bariatric surgical procedure are also covered with documentation of any of the following conditions:

a. Anastomosis, leak at site
b. Anastomosis, marginal ulceration at site
c. Band erosion
d. External band slippage
e. Dehiscence/disruption of staple line
f. Disruption of operative wound
g. "Dumping" syndrome, severe
h. Esophageal dilation, symptomatic
i. Esophagitis confirmed on endoscopy or biopsy
j. Failed weight loss with weight regain due to stomal (pouch) dilation
k. Failed weight loss with esophageal dilation
l. Gastroesophageal reflux disease (GERT)
m. Hemorrhage or hematoma complicating a procedure
n. Intractable vomiting
o. Post-gastric surgery syndromes, e.g. post-gastrectomy syndrome, post-vagotomy syndrome
p. Pouch enlargement
q. Stomal stenosis or dilation documented by endscopy
r. Stricture(s) not amenable to balloon dilation
s. Unspecified and other post-surgical non-absorption, e.g. diarrhea following gastrointestinal surgery
t. Weight loss of twenty percent (20%) or more below the ideal body weight (based upon the 1996 Metropolitan Life Height and Weight tables for men/women)

NOTE: Revisions to a prior ineligible or ***investigational*** bariatric surgical procedure are considered a complication of a non-covered service and therefore no covered. Any bariatric surgery requires precertification.

BIRTHING CENTER

Covered expenses shall include services, supplies and treatments rendered at a ***birthing center*** provided the ***physician*** in charge is acting within the scope of his license and the ***birthing center*** meets all legal requirements.

Services of a midwife acting within the scope of his license or registration are a ***covered expense*** provided that the state in which such service is performed has legally recognized midwife delivery.

BOTULINUM TOXIN TYPE A (Botox) AND/OR BOTULINUM TOXIN TYPE B (MYOBLOC)

Covered expenses shall include ***medically necessary*** care, services and treatment for a ***covered person*** receiving Botox therapy with clinical documentation of conditions such as bleparospasm, post-facial (7^{th} cranial) nerve palsy synkinesis hemifacial spasms, laryngeal spasm, focal dystonia, limb spasticity, cervical dystonia, esophageal achalsia and/or

strabismus. Other specific medical conditions may be eligible for treatment when ***medically necessary*** and not excluded by the ***Plan.***

CARDIAC REHABILITATION PROGRAMS

Covered expenses shall include ***medically necessary*** Phase I or II cardiac rehabilitation programs when rendered:

(a) under the supervision of a ***physician;***

(b) in connection with a myocardial infarction, coronary occlusion, or coronary by-pass surgery;

(c) initiated within twelve (12) weeks after other treatment for the medical condition ends; and

(d) in a medical care ***facility*** as defined herein.

CLINICAL TRIALS

Covered expenses for clinical trials shall be limited to a ***covered person*** who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either: (1) the referring health care professional is a ***preferred provider*** and has concluded that the ***covered person's*** participation in such trial would be appropriate; or (2) the ***covered person*** provides medical and scientific information establishing that the ***covered person's*** participation in such trial would be appropriate.

Covered expenses shall include routine services, supplies and treatment eligible for coverage under this ***Plan*** that would be required or covered if the ***covered person*** was receiving standard, non-investigational treatment. Such routine services, supplies and treatment include those by a ***physician***, diagnostic or laboratory tests, and other ***covered expenses*** provided during the course of treatment.

CHIROPRACTIC CARE

Covered expense includes services provided by a licensed M.D., D.O. or D.C. for consultation, x-rays and treatment, subject to the ***maximum benefit*** shown on the *Schedule of Benefits.*

COSMETIC SURGERY/RECONSTRUCTIVE SURGERY

Cosmetic surgery or ***reconstructive surgery*** shall be a ***covered expense*** provided:

1. A ***covered person*** receives an ***injury*** as a result of an accident and, as a result, requires surgery. ***Cosmetic surgery*** or ***reconstructive surgery*** and treatment must be for the purpose of restoring the functions of the body which are lost or impaired due to ***injury.***

2. It is required to correct a congenital anomaly, for example, a birth defect.

3. It is required as the result of ***illness*** or previous surgery.

4. It is for reconstructive breast surgery necessary because of a mastectomy. A breast reduction surgery for any other reason is <u>not</u> a ***covered expense.***

5. It is for reconstructive breast reduction on the non-diseased breast to make it equal in size with the diseased breast following reconstructive surgery on the diseased breast.

DENTAL SERVICES

Covered expenses shall include repair of sound natural teeth or surrounding tissue provided it is the result of an ***injury.*** Treatment must begin within ninety (90) days of the date of such ***injury*** and be completed within twelve (12) months after the ***injury.*** Damage to the teeth as a result of chewing or biting shall not be considered an ***injury*** under this benefit. The surgical removal of bony or soft tissue impacted wisdom teeth shall be considered a ***covered expense.***

Subject to precertification, ***covered expenses*** shall include ***medically necessary*** dental restorations directly caused by a medical condition or which are required in order to perform a covered surgery or treatment. Prior to the start of any dental work under this provision, ***covered persons*** must contact the ***Utilization Review Organization*** for authorization and submit a proposed treatment plan to determine whether a dental service shall be deemed ***medically necessary.*** Any treatment not deemed ***medically necessary*** by the ***Utilization Review Organization*** shall not be deemed a ***covered expense.*** Services and treatments specifically excluded under this provision shall include, but are not limited to dental implants and related services; occlusal rehabilitation and reconstructions; orthodontic services; routine dental care; repair and replacement of fixed or removable complete or partial dentures.

DIABETIC SUPPLIES AND EDUCATION

Covered expenses shall include diabetic education and training for ***covered persons*** diagnosed with diabetes to improve self-management. Diabetic education must be prescribed by the patient's ***physician*** as part of a comprehensive plan of care related to diabetes to ensure therapy, compliance, necessary skills and knowledge in the management of diabetes. Training must be done in person. The following diabetic supplies are covered when prescribed by a ***physician*****:**

a. blood glucose monitor (standard model);

b. blood glucose monitor for the legally blind;

c. test strips for glucose monitors and urine test strips;

d. injection aids;

e. syringes and lancets;

f. drawing-up devices and monitors for the visually impaired;

g. any other device, medication, equipment or supply for which coverage is required under ***Medicare,*** when purchased through an eligible ***durable medical equipment*** provider or as specifically listed as covered under the *Prescription Drug Program.*

DIAGNOSTIC SERVICES AND SUPPLIES

Covered expenses shall include services and supplies for diagnostic laboratory, pathology, ultrasound, nuclear medicine, magnetic imaging and x-ray.

DURABLE MEDICAL EQUIPMENT

Rental or purchase whichever is less costly of necessary ***durable medical equipment*** and is prescribed by a ***physician*** and required for therapeutic use by the ***covered person*** shall be a ***covered expense.*** Equipment ordered prior to the ***covered person's effective date*** of coverage is not covered, even if delivered after the ***effective date*** of coverage. Repair or replacement of purchased ***durable medical equipment*** which is ***medically necessary*** due to normal use or physiological change in the patient's condition will be considered a ***covered expense.*** Maintenance contracts for purchased equipment will be considered a ***covered expense.***

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the ***covered person's*** condition, or where there exists a reasonably feasible and medically appropriate alternative piece of

equipment which is less costly than the equipment furnished, will be covered based on the usual charge for equipment which would meet the ***covered person's*** medical needs.

EMERGENCY SERVICES/EMERGENCY ROOM

Coverage for emergency room treatment shall be paid in accordance with the *Schedule of Benefits* provided the condition meets the definition of ***emergency*** herein. Emergency room treatment for conditions that do not meet the definition of ***emergency*** or are received subsequent to the initial treatment shall be paid as non-***emergency*** charges. Services of ***nonpreferred providers*** shall be paid at the ***nonpreferred provider*** level.

EXTENDED CARE FACILITY

Extended care facility services, supplies and treatments shall be a ***covered expense*** provided:

1. The ***covered person*** was first confined in a ***hospital***;

2. The attending ***physician*** recommends extended care ***confinement*** for a convalescence from a condition which caused that ***hospital confinement,*** or a related condition;

3. The ***covered person*** is under a ***physician's*** continuous care and the ***physician*** certifies that the ***covered person*** must have twenty-four (24) hours-per-day nursing care and completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge.

Covered expenses shall include:

1. ***Room and board*** (including regular daily services, supplies and treatments furnished by the ***extended care facility)*** limited to the ***facility's*** average ***semiprivate*** room rate; and

2. Other services, supplies and treatment ordered by a ***physician*** and furnished by the ***extended care facility*** for ***inpatient*** medical care.

Extended care facility benefits are limited as shown on the *Schedule of Benefits*.

FACILITY PROVIDERS

Covered expenses shall include services of ***facility*** providers if such services would have been covered if performed in a ***hospital*** or ***ambulatory surgical facility.***

HEARING SERVICES OR DEVICES

Covered expenses shall include charges for hearing aid services, supplies and routine hearing exams, except for hearing screenings included in a routine exam (see *Preventive Care),* including external, semi-implantable middle ear, and implantable bone conduction hearing aids, unless specifically provided herein. Benefits shall be limited as specified on the *Schedule of Benefits.*

HOME HEALTH CARE

Home health care enables the ***covered person*** to receive treatment in his home for an ***illness*** or ***injury*** instead of being confined in a ***hospital*** or ***extended care facility.*** The diagnosis, care and treatment must be certified by the attending ***physician*** and must be contained in a ***home health care*** plan which is reviewed and approved by the patient's ***physician*** at least every thirty (30) days.

Covered expenses shall include:

1. Part-time or intermittent nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse in the patient's home;

2. Services provided on an intermittent basis in the patient's home;

3. Medical supplies including drugs and biological;

4. ***Durable medical equipment;***

5. Enteral nutrition/tube feeding when it is the sole source of nutrition, Nursing visits will only be covered for the purpose of instructing the patient and/or caregiver to initiate and terminate the feeding, unless the patient and/or caregiver cannot perform these tasks, in which case, the visits will be subject to the maximum benefit specified on the *Schedule of Benefits.*

6. Home Infusion/Medication Administration Therapy, including:

   - Intravenous, intramuscular, or subcutaneous administration of medication, except for those injectables specifically listed as covered under the *Prescription Drug Program.*
   - Hydration therapy.
   - Blood/blood components.
   - Total parenteral nutrition.
   - Chemotherapy.
   - Intravenous catheter care.
   - Intravenous antibiotic therapy.

   Growth hormone therapy is covered under the Specialty Pharmacy benefit.

A visit by a member of a ***home health care*** team and (4) hours of ***home health aide service*** will each be considered one (1) ***home health care*** visit. ***Home health*** visits are limited to three (3) per day.

HOSPICE CARE

Hospice care is a health care program providing a coordinated set of services rendered in the patient's or caregiver's home settings for a ***covered person*** suffering from a condition that has a terminal prognosis.

Hospice benefits will be covered only if the ***covered person's*** attending ***physician*** certifies that:

1. The ***covered person*** is terminally ill;

2. The ***covered person*** has a life expectancy of six (6) months or less;

3. A caregiver (family member, friend, or other individual who provides care free of charge) must be available in the home twenty-four (24) hours a day to provide support for the ***covered person's*** daily needs and;

4. The ***covered person*** must meet the requirements of the ***hospice agency.***

Covered expenses shall include:

1. Intermittent services, supplies and treatment provided by a ***hospice*** to a ***covered person*** in a home setting.

2. Respite care, or admission of the patient to an approved facility for up to five (5) days to provide rest for the patient's family or caregiver, limited to once every twenty-one days:

3. Continuous home care, or twenty-four (24) skilled care, provided by a Registered Nurse or Licensed Practical Nurse during a period of crisis, as determined by the ***hospice agency,*** in order to maintain the patient at home,

continuous care is generally delivered in four (4) to eight (8) hours blocks and is limited to seventy-two (72) hours per period of crisis; and

4. ***Inpatient*** acute care for pain control or symptom management that cannot be provided in a home setting.

Charges ***incurred*** during periods of remission are not eligible under this provision of the ***Plan.*** Any ***covered expense*** paid under ***hospice*** benefits will not be considered a ***covered expense*** under any other provision of this ***Plan.***

HOSPITAL/AMBULATORY SURGICAL FACILITY

Inpatient hospital admissions and ***outpatient*** surgical procedures are subject to precertification. Failure to obtain precertification will result in a reduction of benefits, refer to *Utilization Review.* ***Covered expenses*** shall include:

1. ***Room and board*** for treatment in a ***hospital,*** including ***intensive care units,*** cardiac care units and similar necessary accommodations. ***Covered expenses*** for ***room and board*** shall be limited to the ***hospital's semiprivate*** rate. ***Covered expenses*** for ***intensive care*** or cardiac care units shall be the ***negotiated rate*** for ***preferred providers*** and the ***customary and reasonable amount*** for ***nonpreferred providers.*** In a ***hospital*** having only private rooms, ***covered expenses*** for ***room and board*** shall be limited to the ***hospital's*** standard private room rate. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the ***covered person.***

2. Miscellaneous ***hospital*** services, supplies, and treatments including, but not limited to:
   A. Admission fees, and other fees assessed by the ***hospital*** for rendering ***medically necessary*** services, supplies and treatments;
   B. Use of operating, treatment or delivery rooms;
   C. Anesthesia, anesthesia supplies and its administration by an employee of the ***hospital;***
   D. Medical and surgical dressings and supplies, casts and splints;
   E. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
   F. Drugs and medicines (except drugs not used or consumed in the ***hospital);***
   G. X-ray and diagnostic laboratory procedures and services;
   H. Oxygen and other gas therapy and the administration thereof;
   I. Therapy services.

3. Services, supplies and treatments described above furnished by an ***ambulatory surgical facility,*** including follow-up care provided within seventy-two (72) hours of a procedure.

4. ***Inpatient*** Extended Active Rehabilitation (EAR) services, up to sixty (60) days per calendar year.

5. Preadmission testing (x-rays and lab tests) performed within seven (7) days prior to a ***hospital*** admission which are related to the condition which is necessitating the ***confinement.*** Such tests shall be payable even if they result in additional medical treatment prior to ***confinement*** or if they show that ***hospital confinement*** is not necessary. Such tests shall not be payable if the same tests are performed again after the ***covered person*** has been admitted.

LONG TERM ACUTE CARE (L.T.A.C.)

Covered expenses shall include specialized acute ***hospital*** care for medically complex patients who are critically ill have multi-system complications and/or failures and require hospitalization on an extended basis in a facility offering specialized treatment programs and an aggressive clinical and therapeutic intervention on a 24/7 basis. When ***medical necessity*** criteria for long term acute care are met, benefits are available for no more than a maximum of three hundred sixty-five (365) days while covered by this ***Plan.*** Deductible and ***coinsurance*** provisions apply for each admission. Beds within a facility may be licensed for different levels of care. Even within the same facility, an admission occurs when the patient is moved from a bed licensed for one level of care to a bed licensed for a different level of care.

MASTECTOMY

Covered expense shall include all services, supplies, and treatment of physical complications from all stages of mastectomy, including lymphedemas.

MEDICAL FOODS

Covered expenses shall include medical food used for treatment of metabolic disorders, included in the newborn screening program, including phenylketonuria (PKU), maple syrup urine disease, homocystinuria, and galactosemia. No benefits are payable for foods for any condition not included in the newborn screening program, including lactose intolerance without a diagnosis. To be eligible for medical food benefits, all of the following criteria must be met:

a. the ***covered person*** must be diagnosed with one (1) of the inherited metabolic disorders;

b. the inherited metabolic disorder must involve amino acid, carbohydrate, or fat metabolism and have medically standard methods of diagnosis, treatment and monitoring, including quantification of metabolites in blood, urine, or spinal fluid or enzyme or DNA confirmation in tissues;

c. the ***covered person*** must require specially processed or treated medical foods generally available only under the supervision of an allopathic or osteopathic ***physician;***

d. the medical foods must be prescribed or ordered under the supervision of allopathic or osteopathic ***physician*** as ***medically necessary*** for the therapeutic treatment of one(1) of the inherited metabolic disorders identified above; and

e. the prescribed or ordered specially processed or treated medical foods must be consumed throughout life, without which, the ***covered person*** may suffer serious mental or physical impairment.

Medical record documentation may be required.

Medical food means modified low protein foods and metabolic formulas that are all of the following:

a. formulated to be consumed or administered through the gastrointestinal tract under the supervision of an allopathic or osteopathic ***physician;***

b. processed or formulated to contain less than one (1) gram of protein per unit of serving (modified low protein foods only);

c. processed or formulated to be defiant in one (1) or more of the nutrients present in typical foodstuffs (metabolic formula only);

d. administered for the medical and nutritional management of a ***covered person*** with limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and

e. essential to the ***covered person's*** optimal growth, health and metabolic homeostasis.

f. Medical foods may be purchased from any source. To receive benefits the ***covered person*** must submit a claim form outlining the following information:
   - the ***covered person's*** name, social security number and group number;
   - the name of the prescribing/ordering ***physician;***
   - the ***covered person*** diagnosis for which the medical foods are prescribed/ordered;
   - where the medical foods were obtained, including the name, address and telephone number of the medical food supplier; and

- the amount paid for the medical food, including the original or copy of the dated receipt/proof of purchase.

MENTAL AND NERVOUS DISORDERS/CHEMICAL DEPENDENCY

Inpatient

Subject to the precertification provisions of the ***Plan,*** the ***Plan*** will pay the applicable ***coinsurance*** for ***confinement*** in a ***hospital*** or ***treatment center*** for services, supplies and treatment related to the treatment of ***mental and nervous disorders/ chemical dependency.***

Covered expenses shall include:

1. ***Inpatient hospital*** confinement;

2. Individual psychotherapy;

3. Group psychotherapy;

4. Psychological testing;

5. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same ***professional provider.***

Outpatient

The ***Plan*** will pay the applicable ***coinsurance*** for ***outpatient*** services, supplies and treatment related to the treatment of ***mental and nervous disorders*** or ***chemical dependency.***

Office Visit

The ***Plan*** will pay the applicable ***coinsurance*** for office visits related to the treatment of ***mental and nervous disorders*** and ***chemical dependency.*** ***Covered expenses*** shall include: psychotherapy; therapy services for ***chemical dependency***; diagnostic office visits; office visits for monitoring ***mental and nervous disorders;*** electroconvulsive therapy; and counseling for personal, marriage and family problems. Ten (10) hours of psychological and/or neuropsychological testing per calendar year is covered. The treatment of autism is also a ***covered expense.***

NEUROPSYCHOLOGICAL AND COGNITIVE TESTING

Covered expenses shall include evaluation of mental function when integral to medical care following head trauma, cerebral vascular accident (stroke), transient ischemic attack (TIA) or other decreased mental function related to a documented medical condition, and/or as part of a ***medically necessary*** evaluation of development delay. After the initial evaluation of developmental delay, regardless of the cause of the delay, the only services which are covered for treatment of that condition are physical therapy, occupational therapy and speech therapy.

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a ***covered expense***. Orthopedic shoes or corrective shoes, that are an integral part of a leg brace shall be covered. Repair or replacement of an orthotic which is ***medically necessary*** due to normal use or physiological change in the patient's condition will be considered a ***covered expense*** and limited to once while covered by this ***Plan.***

PHYSICIAN SERVICES

Covered expenses shall include:

1. Medical treatment, services and supplies including, but not limited to: office visits, ***inpatient*** visits, home visits.

2. Surgical treatment. Separate payment will not be made for ***inpatient*** pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

   If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the ***customary and reasonable amount*** or ***negotiated rate*** that is allowed for the primary procedure; fifty percent (50%) of the ***customary and reasonable amount*** or ***negotiated rate,*** as applicable, will be allowed for each additional procedure performed through the same incision. Any procedure that would be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures.

   If multiple unrelated surgical procedures are performed by two (2) or more surgeons in separate operative fields, benefits will be based on the ***customary and reasonable amount*** or ***negotiated rate,*** as applicable, for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the ***customary and reasonable amount*** or ***negotiated rate,*** as applicable, allowed for that procedure.

3. Surgical assistance provided by a ***physician*** if it is determined that the condition of the ***covered person*** or the type of surgical procedure requires such assistance

4. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant.

5. Consultations requested by the attending ***physician*** during a ***hospital confinement.*** The ***Plan*** will pay for one such consultation per ***illness*** or ***injury.*** Consultations do not include staff consultations which are required by a ***hospital's*** rules and regulations.

6. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

7. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.

8. Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

PODIATRY SERVICES

Covered expenses shall include diagnosis, treatment and prevention of conditions of the feet, including surgical services, incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or débridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.

PREGNANCY

Covered expenses for ***pregnancy*** or ***complications of pregnancy*** shall be provided for a covered female ***employee*** or a covered female ***dependent*** of a covered ***employee.***

In the event of early discharge from a ***hospital*** or ***birthing center*** following delivery, the ***Plan*** will cover two (2) Registered Nurse home visits.

The ***Plan*** shall cover services, supplies and treatments for ***medically necessary*** abortions when the life of the mother would be endangered by continuation of the ***pregnancy*** or when the fetus has a known condition which is incompatible with life.

Complications from an abortion for the covered female ***employee*** or a covered ***dependent*** of an ***employee*** shall be a ***covered expense*** whether or not the abortion is a ***covered expense.***

Group health plans generally may not, under federal law, restrict benefits for any ***hospital*** length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. If delivery occurs in the ***hospital,*** the 48-hour period, or 96-hours, begins at the time of delivery. If delivery occurs outside the ***hospital*** and is later ***confined*** to the ***hospital*** in connection with childbirth, the period begins at the time of the ***hospital*** admission. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law require that a provider obtain authorization from the ***Plan*** for prescribing a length of stay not in excess of the above periods. If a newborn remains hospitalized beyond the time frames specified above, the ***confinement*** must be precertified.

Benefits shall also be paid for expenses ***incurred*** by the natural birth mother for the birth of any child legally adopted by the ***covered person,*** provided that:

a. the child is adopted within one (1) year from the date the legal adoption process began, and

b. the ***covered person*** is legally obligated to pay the costs of birth, and

c. the ***covered person*** has provided notice to the ***Plan administrator*** within sixty (60) days of their acceptability to adopt children.

PRESCRIPTION DRUGS

The ***Plan*** shall cover prescription drugs which are approved for general use by the Food and Drug Administration and dispensed through a ***physician's*** office or as take-home drugs from a ***hospital.*** The ***covered person*** must be charged for such drugs. If eligible for coverage, such drugs shall be covered under this provision of the ***Plan*** and not under the *Prescription Drug Program.* The prescription drug ***copay*** described in the section, *Prescription Drug Program,* shall apply toward the *Medical Expense Benefit, Out-of-Pocket Expense Limit* for ***preferred providers***.

PREVENTIVE CARE

Covered expenses shall include the preventive services as recommended by the U.S. Preventive Services Task Force:

Preventive Screenings: abdominal aortic aneurysm by ultrasonography in men aged sixty-five (65) to seventy-five (75) who have never smoked; mammograms with or without clinical breast examination as follows: one (1) baseline mammogram for women age thirty-five (35) through thirty-nine (39) and one (1) mammogram every ***benefit year*** for women age forty (40) and over; one (1) cervical cancer screening and pelvic examination; cholesterol abnormalities; colorectal cancer beginning at age fifty (50) and continuing until age seventy-five (75); diabetes; depression; screening for hearing loss in newborn infants; osteoporosis; screening for visual acuity in children younger than age five (5); physical check-up; prostate examination and PSA test; and any related diagnostic x-ray and laboratory.

Immunizations: preventive immunizations from birth for all ***covered persons.***

Pediatric: All preventive Pediatric Health Care as recommended by the Bright Futures project.

Well Woman Preventive Services:

For the purpose of this provision, the term "woman" shall mean a female, age-appropriate ***covered person***. ***Covered expenses*** for Well Woman Preventive Services shall include:

1. Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The frequency is annually, however, the ***Plan*** recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs and other risk factors.
2. Screening for gestational diabetes in pregnant women between ages twenty-four (24) and twenty-eight (28) weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk of diabetes.
3. Human papillomavirus testing DNA testing in women with normal cytology result. Screening should begin at thirty (30) years of age and should occur no more frequently than once every three (3) years.
4. Annual counseling on sexually transmitted infections for all sexually active women.
5. Annual counseling and screening for human immune-deficiency virus infection or all sexually active women.
6. All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.
7. In conjunction with each birth, comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
8. Annual screening and counseling for interpersonal and domestic violence.

PROSTHESIS

The purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) shall be a ***covered expense***. A prosthesis ordered prior to the ***covered person's effective date*** of coverage is not covered, even if delivered after the ***effective date*** of coverage. Repair or replacement of a prosthesis which is ***medically necessary*** due to normal use or physiological change in the patient's condition will be considered a ***covered expense*** and limited to once while covered by this ***Plan.***

External, semi-implantable middle ear, and implantable bone conduction hearing aids shall be a ***covered expense.*** Benefits shall not exceed a maximum of twenty-five thousand dollars ($25,000) (combined with any other hearing device) per ***covered person.***

REHABILITATIVE SERVICES

Rehabilitative services must be ordered by a ***physician*** to aid restoration of normal function lost due to ***illness*** or ***injury,*** for congenital anomaly, or for prevention of continued deterioration of function. ***Covered expenses*** shall include services of a ***professional provider*** for physical therapy, speech therapy, or respiratory therapy, subject to the ***maximum benefits*** specified on the *Schedule of Benefits*. ***Covered expense*** does not include recreational programs.

Inpatient

Inpatient rehabilitative services are subject to precertification. ***Inpatient*** rehabilitative services shall also include room and board, including regular daily services and supplies furnished by the ***facility***, ***physician*** and ***professional providers.***

Outpatient

Outpatient rehabilitative services shall also include daily services and supplies furnished by the ***facility, physician*** and ***professional providers.***

SECOND SURGICAL OPINION

Benefits for a second surgical opinion will be payable for ***physician's*** services if an elective surgical procedure (non-emergency surgery) is recommended by the ***physician***. The ***physician*** rendering the second opinion regarding the ***medical necessity*** of such surgery must be a board certified specialist in the treatment of the ***covered person's illness*** or ***injury*** and must not be affiliated in any way with the ***physician*** who will be performing the actual surgery.

In the event of conflicting opinions, a request for a third opinion may be obtained. The ***Plan*** will consider payment for a third opinion the same as a second surgical opinion.

SLEEP DISORDERS

Obstructive Sleep Apnea Syndrome

a. Obstructive sleep apnea syndrome is considered clinically significant with documentation of the following:
   - Apneic-hypopneic index ((AHI)* of fifteen (15) or more, or
   - AHI between five (5) and fourteen (14) with documentation of any of the following associated symptoms:
     - excessive daytime sleepiness
     - history of stroke
     - hypertension
     - impaired cognition
     - insomnia
     - ischemic heart disease
     - mood disorders

   *The AHI is the average number of episodes of apnea and hypopnea per hour as recorded by a polysomnography based on a minimum of two (2) hours actual sleep. The polysomnography must be performed by a certified sleep laboratory, either in an overnight laboratory or home setting, and reviewed by a certified practitioner and ***professional provider.***

b. The following treatments for clinically significant obstructive sleep apnea syndrome are considered ***medically necessary***:
   - Continuous positive airway pressure (CPAP) for an adult
   - Oral appliance with document of the following:
     - Polysomnography indicates five (5) or more episodes of apnea per hour during sleep, and
     - Obstructive sleep apnea is not of central nervous system (CNS) origin
   - Uvulopalatopharyngoplasty (UPPP) for an individual who has not responded to or cannot tolerate the use of a CPAP device
   - Hyoid suspension, maxillofacial surgery, including mandibular-maxillary advancement or surgical modification of the tongue with documentation of the following:
     - Objective hypopharyngeal obstruction, and
     - Individual has not responded to or cannot tolerate the use of a CPAP device.

c. The following treatments for obstructive sleep apnea syndrome are considered ***investigational*** based upon insufficient scientific evidence to permit conclusion concerning the effect on health outcomes and insufficient evidence to support improvement of the net health outcome:
   - Laser-assisted uvulopalatoplasty (LAUP)
   - Somnoplasty

Upper Airway Resistance Syndrome

a. Upper airway resistance syndrome is considered clinically significant with documentation of ten (10) episodes of EEG arousal per hour of sleep in association with negative intrathoracic pressures. The following treatments for clinically significant upper airway resistance syndrome are considered ***medically necessary:***
   - Continuous positive airway pressure (CPAP) for an adult
   - Uvlopalaropharyngoplasty (UPPP) for an individual who has not responded to or cannot tolerate the use of a CPAP device.

b. The following treatments for upper airway resistance syndrome are considered ***investigational*** based upon insufficient scientific evidence to permit conclusion concerning the effect on health outcomes and insufficient evidence to support improvement of the net health outcome:
   - Laser-assisted uvulopalatoplasty (LAUP)

- Somnoplasty

SPECIAL EQUIPMENT AND SUPPLIES

Covered expenses shall include ***medically necessary*** special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; disposable supplies required to operate or maintain a covered prosthesis or ***durable medical equipment;*** catheters; allergy serums; crutches; electronic pacemakers; oxygen and the administration thereof, including rental charges for thirty-six (36) months. Beginning six (6) months after the thirty-six (36) month rental period ends, maintenance visits are covered every six (6) months for two (2) years at which time the concentrator will be deemed to have met its reasonable lifetime use and the billing cycle will start again if the patient still needs oxygen; intravenous injections and solutions and their administration; the purchase of one (1) wig per calendar year for the diagnosis of alopecia resulting from ***illness*** *or* ***injury;*** blood and blood components and derivatives that are not donated or replaced; the initial pair of eyeglasses or contact lenses due to cataract surgery subject to the ***maximum benefit*** specified on the *Schedule of Benefits* and prescribed within six (6) months following surgery; soft lenses or sclera shells intended for use in the treatment of ***illness*** or ***injury*** of the eye; surgical dressings and other medical supplies ordered by a ***professional provider*** in connection with medical treatment, but not common first aid supplies.

STERILIZATION

Covered expenses shall include elective sterilization procedures for the covered ***employee*** or covered spouse. Reversal of sterilization is not a ***covered expense.***

TEMPOROMANDIBULAR JOINT DYSFUNCTION

Surgical and nonsurgical treatment of temporomandibular joint (TMJ), myofacial pain syndrome or non-surgical orthognathic treatment shall be a ***covered expense,*** but shall not include orthodontia or prosthetic devices prescribed by a ***physician*** or ***dentist***. The ***maximum benefit*** payable for diagnosis and treatment of TMJ, myofacial pain syndrome or orthognathic disorders per ***covered person*** is shown in the *Schedule of Benefits.* This limitation shall apply whether treatment is provided by a ***hospital, physician, dentist,*** physical therapist or oral surgeon.

THERAPY SERVICES

Covered expenses shall include the ***facility*** and services of a ***professional provider*** for x-ray, radium or radiotherapy treatment; chemotherapy; dialysis therapy or treatment; and IV infusion therapy, whether rendered on an ***inpatient*** or ***outpatient*** basis. The services of technicians are included. Chemotherapy and infusions must be precertified, regardless of the place of service. Failure to obtain precertification shall result in a reduction in benefits.

TRANSPLANT

Services, supplies and treatments in connection with the listed human-to-human organ and tissue transplant procedures will be considered ***covered expenses*** subject to the following conditions:

1. When the recipient is covered under this ***Plan,*** the ***Plan*** will pay the recipient's ***covered expenses*** related to the transplant.

2. When both the donor and recipient are covered under this ***Plan,*** the ***Plan*** will pay the donor's ***covered expenses*** related to the transplant, will be processed under the recipient’s benefit.

3. Expenses ***incurred*** by the donor who is not ordinarily covered under this ***Plan*** according to *Eligibility* requirements will be ***covered expenses*** to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, within six (6) months following the transplant and provided the recipient is covered under this ***Plan.***

4. Surgical, storage and transportation costs directly related to procurement and transplant of an organ or tissue used in transplant procedure will be covered for each procedure completed if the donor or recipient lives more than seventy-five (75) from the transplant site. Such charges do not count for the initial transplant evaluation but will count charges for treatment of complications or for routine transplant follow-up. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a ***covered expense*** under this ***Plan.***

5. Marrow search and procurement when the ***covered person*** is the recipient of a covered allogenic transplant.

6. Air and ground transportation of a medical team to and from the transplant site in the U.S. for the procurement of an organ or tissue that is subsequently transplanted.

If a ***covered person's*** transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement as described above.

The following are covered transplant procedures:

1. Organ transplants, including heart, heart/lung (lobar, single and double lung), kidney, pancreas, kidney/pancreas and liver.

2. Small bowel, small bowel-multivisceral.

3. Corneal transplants.

4. Autologous islet transplantation (AECT).

5. Allogenic, autologous and/or syngenic bone marrow transplants.

Benefits for allogenic, autologous and/or syngenic bone marrow transplants (including peripheral stem cell rescue (PSCR) procedures and/or HDC or HDR are not available for treatment of all conditions or all stages of a condition, even is a provider recommends such treatment.

WELL NEWBORN CARE

The ***Plan*** shall cover well newborn care (including circumcision) while the mother is confined for delivery. ***Covered expenses*** for services, supplies or treatment of the newborn child shall be considered charges of the child and as such, subject to a separate deductible (if applicable), ***copay*** and ***coinsurance*** from the mother.

MEDICAL EXCLUSIONS

In addition to *Plan Exclusions*, no benefit will be provided under this ***Plan*** for medical expenses for the following:

1. Charges for services, supplies or treatment for the reversal of sterilization procedures.

2. Charges for services, supplies or treatment related to the diagnosis or treatment of infertility and artificial reproductive procedures, including, but not limited to: artificial insemination, invitro fertilization, surrogate mother, fertility drugs when used for treatment of infertility, embryo implantation, or gamete intrafallopian transfer (GIFT).

3. Charges for services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

4. Charges for treatment or surgery for sexual dysfunction.

5. Charges for ***hospital*** admission on Friday, Saturday or Sunday unless the admission is an ***emergency*** situation, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, ***hospital*** expenses will be payable commencing on the date of actual surgery.

6. Charges for ***inpatient room and board*** in connection with a ***hospital confinement*** primarily for diagnostic tests or therapy, unless it is determined by the ***Plan*** that ***inpatient*** care is ***medically necessary.***

7. Charges for biofeedback therapy.

8. Charges for services, supplies or treatments which are primarily educational in nature, except as specified in *Medical Expense Benefit, Patient Education and Preventive Care;* charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.

9. Except as specifically stated in *Medical Expense Benefit, Dental Services*, charges for or in connection with: treatment of ***injury*** or disease of the teeth; oral surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants.

10. Except as specified in *Preventive Care,* charges for routine vision examinations and eye refractions; orthoptics; eyeglasses or contact lenses, except as specifically stated under *Special Equipment and Supplies*; dispensing optician's services.

11. Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such surgery.

12. Except as ***medically necessary*** for the treatment of diabetes, neurological involvement or peripheral-vascular ***illness,*** charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.

13. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a ***physician,*** such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-hospital adjustable beds, exercise equipment or other items considered "luxury medical equipment", such as, motorized wheelchairs or other vehicles, bionic or computerized artificial limbs

14. Except as mandated by Healthcare Reform, charges for nonprescription drugs, such as vitamins (except prenatal vitamins), cosmetic dietary aids, and nutritional supplements, except as specified herein.

15. Expenses for a ***cosmetic surgery*** or ***cosmetic treatment*** and all related services, except as specifically stated in *Medical Expense Benefit, Cosmetic Surgery.*

16. Charges ***incurred*** as a result of, or in connection with, ***cosmetic surgery*** or any procedure or treatment excluded by this ***Plan*** which has resulted in medical complications, except for complications from a non-covered abortion.

17. Charges for services provided to a ***covered person*** for an elective abortion. However, complications from such procedure shall be a ***covered expense.*** Refer to *Medical Expense Benefit, Pregnancy* for ***Plan's*** coverage of non-elective abortions.

18. Except as specified in *Preventive Care,* charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of a treatment plan for another ***illness;*** however, ***medically necessary*** charges for bariatric surgery, as specified in *Bariatric Surgery* will be covered.

19. Except a specified in *Preventive Care,* a charge for services, supplies and treatment for smoking cessation programs, or related to the treatment of nicotine addiction, including smoking deterrent patches.

20. Except as specified in *Preventive Care* or *Hearing Services or Devices,* charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid; or charges for a cochlear implant.

21. Charges related to acupuncture or acupressure treatment.

22. Charges for ***custodial care,*** domiciliary care or rest cures.

23. Charges for travel, meals or accommodations, whether or not recommended by a ***physician,*** except as specifically provided herein.

24. Except as specified in *Special Equipment and Supplies,* charges for wigs, artificial hair pieces, artificial hair transplants, or any drug - prescription or otherwise -used to eliminate baldness or promote hair growth.

25. Charges for expenses related to hypnosis.

26. Charges for prescription drugs that are covered under the *Prescription Drug Program.*

27. Charges for any services, supplies or treatment not specifically provided herein.

28. Charges for professional services billed by a ***physician*** or Registered Nurse, Licensed Practical Nurse or Licensed Vocational Nurse who is an employee of a ***hospital*** or any other ***facility*** and who is paid by the ***hospital*** or other ***facility*** for the service provided.

29. Charges for environmental change including ***hospitalization*** or ***physician*** charges connected with prescribing an environmental change.

30. Charges for ***room and board*** in a ***facility*** for days on which the ***covered person*** is permitted to leave (a weekend pass, for example.)

31. Charges for replacement braces of the leg, arm, back, neck or artificial arms or legs, unless there is sufficient change in the ***covered person's*** physical condition to make the original device no longer functional.

32. Charges for activity therapy, milieu therapy or any care primarily intended to assist an individual in the activities of daily living or for the comfort or convenience of the patient or family member except for limited ***hospice*** benefits as specified herein.

33. Charges for non-traditional or alternative medical therapies, e.g. interventions, services or procedures not commonly accepted as part of allogenic or osteopathic practices, naturopathic and homeopathic medicine, diet therapies, nutritional or lifestyle therapies and aromatherapy.

34. Charges for a ***covered person*** receiving Botox therapy, regardless of ***medical necessity*** and/or recommendation by a ***professional provider*** for any of the following reasons:
    a. Headache, including cerviogenic, cluster, migraine or tension headache; or
    b. Fibromyositis; or
    c. Painful cramps; or
    d. Anal sphincter dysfunction; or
    e. Lower urinary tract dysfunction (e.g. detrusor overactivity/overactive bladed and detrusor-sphincter dyssynergia); or
    f. Bell's palsy; or
    g. Stuttering; or
    h. Irritable colon; or
    i. Biliary dyskinesia; or
    j. Temporomandibular joint disorders; or
    k. Chronic low back pain; or
    l. Chronic neck pain; or
    m. Gastroparesis; or
    n. Clubfoot; or
    o. Cranial/facial pain of unknown etiology; or
    p. Piriformis syndrome; or
    q. Pylorospasm; or
    r. Chronic constipation; or
    s. Wrinkles, frown lines; or
    t. Aging neck; or
    u. Blepharoplasty (eye lids).

35. Charges for services related to improving cognitive functioning (i.e. higher brain functions), reinforcing or re-establishing previously learned thought processes, compensary training, sensory integrative activities, or services related to employability.

36. Charges for complications of body piercing, implants (body art) and/or tattooing, e.g. the evaluation, treatment, removal, and/or lacerations, infections, cellulites and keloids.

37. Charges for counseling in the absence of ***illness*** or ***injury,*** including, but not limited to, marital, education, social, behavior modification services, or recreational therapy; or counseling with the patient's friends, employer, school counselor or school teacher.

38. Charges for court-ordered testing, treatment or therapy, unless such services are otherwise covered under this ***Plan.***

39. Charges for all dietary, caloric and nutritional supplements, e.g. specialized formulas for infants, children or adults or other special foods or diets, even if prescribed by a ***professional provider,*** except as specified in *Medical Foods.*

40. Charges for repair costs that exceed the replacement cost of an item; repair or replacement costs that are lost or damaged due to neglect or use not recommended by the manufacturer; medical equipment and/or supplies that can be purchased over the counter; items primarily for personal comfort, convenience or assistance in daily living; supplies used by a provider during office treatments; artificial organs determined to be ***experimental/investigational.***

41. Charges for services related to a surrogate ***pregnancy.***

42. No benefits are payable for medical foods for the following: foods for any conditions other than those inherited metabolic disorders as specified in *Medical Foods;* natural foods that are naturally low in protein and/or glactose; spices or flavorings; foods/flavorings available to any person, even those without inherited metabolic disorders that may be purchased without a prescription or that do not require supervision by an allopathic or osteopathic provider.

43. Charges for prescription medications and over-the-counters, including pharmaceutical manufacturer's samples, dispensed to the patient in the office by any mode of administration. This does not include eligible injectable drugs administered in the provider's office. Such eligible drugs must be obtained through the Specialty Pharmacy Program.

44. Charges for ***outpatient*** therapy, ***outpatient*** cardiac rehabilitation and ***inpatient*** extended active rehabilitation for these items: cognitive therapy; services rendered after a patient has met functional goals and no objectively measurement improvement is reasonably expected, custodial therapy, massage therapy or computer speech training/therapy programs or devices.

45. Charges for routine care or services not directly related to an ***illness*** or ***injury,*** except as specified in *Preventive Care.*

46. Charges for screening and/or diagnostic testing or treatment without a personal history of a specific diagnosis, except as specified in *Preventive Care.*

47. Charges for high-dose chemotherapy, high dose radiation or other services administered with a non-covered transplant.

48. Charges for transportation or travel expenses, except as specified

PRESCRIPTION DRUG PROGRAM

The ***employer*** has contracted with a nationwide network of ***participating pharmacies*** to provide prescription drugs and medicines at a reduced rate to ***covered persons. Covered expenses,*** limitations and exclusions for prescription drugs are determined through the referenced contract. The Prescription Drug Program described herein is a separate benefit from the Medical Expense Benefit of the ***Plan.*** However, benefits of the Prescription Drug Program are subject to the ***maximum benefit*** while covered by this ***Plan*** as shown on the *Schedule of Benefits, Medical Benefits.*

The prescription drug ***copays*** will apply to the *Medical Expense Benefit* ***preferred provider*** out-of-pocket expense limit. Once the ***benefit year preferred provider*** out-of-pocket expense limit has been reached, the ***Plan*** will pay for ***covered persons*** covered prescription drugs at 100% for the remainder of the ***benefit year.***

There are two (2) aspects of the Prescription Drug Program.

PHARMACY OPTION

Participating pharmacies have contracted with the ***Plan*** to charge ***covered persons*** reduced fees for covered prescription drugs.

The ***copay*** is applied to each covered pharmacy drug and is shown on the S*chedule of Benefits*. Any one prescription is limited to a thirty (30) day supply.

If a drug is purchased from a ***nonparticipating pharmacy*** or a ***participating pharmacy*** when the ***covered person's*** ID card is not used, the ***covered person*** must pay the entire cost of the prescription. No benefits are payable under this ***Plan.***

MAIL ORDER OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer ***covered persons*** significant savings on prescriptions.

The ***copay*** is applied to each covered mail order prescription charge and is shown on the *Schedule of Benefits.* Any one prescription is limited to a ninety (90) day supply.

PRIOR AUTHORIZATION

Certain categories of medication require prior authorization from the Pharmacy Benefit Manager. These categories include, but are not limited to:

1. Acne Medication – Acne medications with Tretionin agents are covered for those under age twenty-four then require prior authorization.

2. Anti-Fungual.

3. Migraine Medications.

4. Certain Injectable Drugs.

COVERED PRESCRIPTION DRUGS

1. All drugs prescribed by a ***physician*** that require a prescription either by federal or state law, except insulin and drugs excluded by the ***Plan.***

2. All compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.

3. Diabetic supplies when prescribed by a ***physician.***

4. Contraceptives.

5. Over-the counter medications as mandated by Healthcare Reform.

For a complete listing of covered prescription drugs, refer to the Pharmacy Benefit Management contract.

LIMITS TO THIS BENEFIT

This benefit applies only when a ***covered person incurs*** a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a ***physician.***

2. Refills up to one year from the date of order by a ***physician.***

PRESCRIPTION EXCLUSIONS

In addition to the *Plan Exclusions,* no prescription benefit shall be payable for the following:

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin, or over the counter medications which can be purchased as specifically stated herein.

2. Devices of any type, even though such devices may require a prescription. These include, but are not limited to: therapeutic devices, artificial appliances, glucose monitors, braces, support garments, or any similar device.

3. Immunization agents or biological sera.

4. A drug or medicine labeled: “Caution - limited by federal law to investigational use.”

5. Experimental drugs and medicines, even though a charge is made to the ***covered person*** including DESI drugs (drugs determined by the FDA as lacking substantial evidence of effectiveness.)

6. Any charge for the administration of a covered prescription drug.

7. Any drug or medicine that is consumed or administered at the place where it is dispensed, except as mandated by Healthcare Reform.

8. A drug or medicine that is to be taken by the ***covered person***, in whole or in part, while ***hospital confined.*** This includes being confined in any institution that has a facility for dispensing drugs.

9. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.

10. A charge for fertility or infertility medication.

11. A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or diabetic supplies. Certain medical foods are covered under the *Medical Expense Benefit.*

12. A charge for any drug not approved by the Food and Drug Administration (FDA).

13. A charge for impotence medications or to treat sexual dysfunction.

14. A charge for performance, athletic performance or lifestyle enhancement drugs or supplies).

15. A charge for prescriptions or refills for drugs that are lost, stolen, spilled, spoiled or damaged,

16. A charge for drug delivery implants.

17. A charge for any prescription drug dispensed in unit-dose packaging unless that is the only form in which the drug is available.

For a complete listing of prescription exclusions, refer to the Pharmacy Benefit Management contract.

PLAN EXCLUSIONS

The ***Plan*** will not provide benefits for any of the items listed in this section, regardless of ***medical necessity*** or recommendation of a ***physician*** or ***professional provider.***

1. Charges for services, supplies or treatment from any ***hospital*** owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.

2. Charges for an ***injury*** sustained or ***illness*** contracted while on active duty in military service, unless payment is legally required.

3. Charges for services, supplies or treatment for treatment of ***illness*** or ***injury*** which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.

4. Any condition for which benefits of any nature are recovered or are found to be recoverable, either by adjudication or settlement, under any Workers' Compensation law, Employer's liability law, or occupational disease law, even though the ***covered person*** fails to claim rights to such benefits or fails to enroll or purchase such coverage.

5. Charges in connection with any ***illness*** or ***injury*** arising out of or in the course of any employment intended for wage or profit, including self-employment.

6. Charges made for services, supplies and treatment which are not ***medically necessary*** for the treatment of ***illness*** or ***injury,*** or which are not recommended and approved by the attending ***physician,*** except as specifically stated herein, or to the extent that the charges exceed the ***customary and reasonable amount,*** exceed the ***negotiated rate*** or ***Medicare*** – like rate, as applicable.

7. Charges in connection with any ***illness*** or ***injury*** of the ***covered person*** resulting from or occurring during the ***covered person's*** commission or attempted commission of a criminal battery or felony. Claims shall be denied if the ***Plan administrator*** has reason to believe, based on objective evidence such as police reports or medical records, that a criminal battery or felony was committed by the ***covered person.***

8. To the extent that payment under this ***Plan*** is prohibited by any law of any jurisdiction in which the ***covered person*** resides at the time the expense is ***incurred.***

9. Charges for services rendered and/or supplies received prior to the ***effective date*** or after the termination date of a person's coverage.

10. Any services, supplies or treatment for which the ***covered person*** is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.

11. Charges for services, supplies or treatment that is considered ***experimental/investigational,*** except as specified herein***.***

12. Charges for services, supplies or treatment rendered by any individual who is a ***close relative*** of the ***covered person*** or who resides in the same household as the ***covered person.***

13. Charges for services, supplies or treatment rendered by physicians or ***professional providers*** beyond the scope of their license; for any treatment, ***confinement*** or service which is not recommended by or performed by an appropriate ***professional provider.***

14. Charges for ***illnesses*** or ***injuries*** suffered by a ***covered person*** due to the action or inaction of any party if the ***covered person*** fails to provide information as specified in *Subrogation/Reimbursement.*

15. Claims not submitted within the ***Plan's*** filing limit deadlines as specified in *Claim Filing Procedures.*

16. Charges for e-mail, internet or telephone consultations, completion of claim forms, charges associated with missed appointments.

17. Charges for services, supplies or treatment for ***covered persons*** who are Native American which are rendered by Indian Health Services or Contract Health Services, or for any charges for services, supplies, or treatment rendered by any other health care provider wherein Indian Health Services/Contract Health Services made a referral for such.

18. Charges for services, supplies, care or treatment to a ***covered person*** for an ***injury*** which occurred as a result of that ***covered person's*** illegal use of alcohol. Claims shall be denied if the ***Plan administrator*** has reason to believe, based on objective evidence such as police reports or medical records of the ***covered person's*** illegal use of alcohol. Expenses will be covered for injured ***covered persons*** other than the person illegally using alcohol and expenses will be covered for ***chemical dependency*** treatment as specified on the *Schedule of Benefits*. This exclusion does not apply if the ***injury*** resulted from an act of domestic violence or an underlying medical condition.

19. Charges for services, supplies, care or treatment to a ***covered person*** for ***injury*** resulting from that ***covered persons*** voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a ***physician.*** Expenses will be covered for injured ***covered persons*** other than the person using controlled substances and expenses will be covered for ***chemical dependency*** as specified herein.

20. Charges for care and treatment of an ***injury*** or ***illness*** that results from activity where the ***covered person*** is found by a court of competent jurisdiction and/or a jury of his/her peers to have been negligent in his/her actions, as "negligence" is defined by the jurisdiction where the activity occurred,

21. Charges ***incurred*** outside the United States if the ***covered person*** traveled to such a location for the sole purpose of obtaining services, supplies or treatment.

ELIGIBILITY

This section identifies the ***Plan's*** requirements for a person to be eligible to enroll for coverage under this ***Plan.*** Refer to the sections entitled, *Enrollment,* and *Effective Date of Coverage* for more information about the ***Plan's*** requirements for coverage hereunder.

The ***employer*** engages the use of ***measurement periods*** for tracking an ***employee's hours of service.*** If during a ***measurement period,*** the ***employee*** averages thirty (30) ***hours of service*** per ***week,*** the ***employee*** will be deemed eligible to enroll for coverage under this ***Plan*** as a ***full-time, regular employee.*** For the purpose of the following provisions on ***employee*** eligibility under the terms of the ***Plan,*** whether an ***employee*** averages thirty (30) ***hours of service*** per ***week*** will be determined in accordance with the policies and procedures adopted by the ***employer*** which are determined in a manner consistent with the Internal Revenue Code Section 4980H and the regulations issued thereunder.

The ***employer*** has the option of engaging a "Monthly***" measurement period*** for some ***employee*** classifications, and the "Look Back" ***measurement period*** for other ***employee*** classifications:

1. The "Monthly" ***measurement period*** is for those ***employees*** who are reasonably determined at the time of hire to be a ***full-time, regular employee.***

2. The "Look Back" ***measurement period*** is for those ***employees*** whose ***hours of service*** cannot be categorized as ***full-time, regular*** and are generally placed in the "Look Back" ***measurement period*** method***.*** The Look Back ***measurement period*** method consists of three components:

   A. A ***measurement period*** shall be for the purpose of tracking an ***employee's hours of service*** during the ***measurement period;***

   B. The ***administrative period*** shall be for the purpose of assessing an ***employee's*** eligibility for coverage under the ***Plan,*** prepare and distribute enrollment materials, and allow time for ***employee*** submission of properly completed application for enrollment by the end of the ***administrative period.***

   C. The ***stability period*** shall be for the purpose of establishing the period of time the eligible, enrolled ***employee*** shall remain on the ***Plan*** if the ***employee*** met the eligibility criteria during the ***measurement period***, subject to any ***break in service***, and *Termination of Coverage* provisions of the ***Plan.***

   After the ***initial measurement period***, the ***stability period*** and the ***standard measurement period*** overlap on the time line.

EMPLOYEE ELIGIBILITY

NEW HIRES

For Full-time, Regular Employees on the Monthly Measurement or Look Back Measurement Period Method:

All ***full-time*** or ***part-time employees*** working at least thirty (30) hours per week shall be eligible to enroll for coverage under this ***Plan.*** This does not include temporary ***employees.***

For Qualifying Part-time Employees on the Look Back Measurement Period Method:

Any other ***employees,*** including, but not limited to, ***seasonal employees***, who are not ***full-time, regular employees*** to the extent that such ***employees*** average thirty (30) ***hours of service*** per ***week*** over the ***employee's*** applicable ***initial measurement period***, shall be eligible to enroll for coverage under this ***Plan*** during the applicable ***administrative period.***

If a ***qualifying part-time employee*** transfers to a ***full-time, regular employee*** position prior to the start of the ***qualifying part-time employee's new employee stability period,*** the ***employee*** will become eligible for coverage as a ***full-time, regular employee.***

FOR ONGOING EMPLOYEES ON THE LOOK BACK MEASUREMENT PERIOD METHOD

Once an ***employee*** has completed the ***standard measurement period,*** eligibility will be based solely on the ***employee's hours of service*** during the ***standard measurement period.*** Any ***employee*** who averages thirty (30) ***hours of service*** per ***week*** during the ***standard measurement period (ongoing employees)*** will be eligible for coverage under the ***Plan*** during the next ***ongoing employee stability period*** to the extent that the ***ongoing employee*** remains employed, subject to the ***Plan's break in service*** rules, and *Termination of Coverage* provisions of the ***Plan.***

BREAK IN SERVICE RULES

1. If the ***employee*** experiences a ***break in service*** during a ***measurement period*** and then again resumes ***hours of service,*** such ***employee*** will be treated as a New Hire ***employee*** upon the date that the ***employee*** resumes ***hours of service*** for the ***employer.***

2. If during an ***ongoing employee stability period,*** the ***employee*** experiences a period without any ***hours of service,*** and subsequently resumes ***hours of service*** but does not experience a ***break in service***, the ***employee*** will be treated as a continuous ***employee.*** Such an ***employee*** will be eligible for coverage under the ***Plan*** upon return to work if they were enrolled in coverage prior to the start of the period with no ***hours of service***.

   Such coverage will be effective on the first day of month that coincides with or follows the date the ***employee*** resumes ***hours of service,*** provided the ***employee*** submits the completed application for enrollment to the ***employer*** within thirty (30) days of resuming ***full-time*** status.

   Prior benefit accumulators shall apply as though there was no break in coverage for any ***employee*** that experiences a ***break in service*** and then returns to coverage under the ***Plan.***

3. Impact of ***special unpaid leaves of absence***: If the ***employee*** takes a ***special unpaid leave of absence*** during a ***measurement period***, the ***employer*** will disregard all consecutive ***weeks*** of such unpaid leave when determining the average ***hours of service*** during the applicable ***measurement period.***

ADDITIONAL TERMS OF ELIGIBILITY FOR QUALIFYING PART-TIME EMPLOYEES AND ONGOING EMPLOYEES ON THE LOOK BACK MEASUREMENT PERIOD METHOD

The ***employer*** will determine a ***qualifying part-time employee's*** and an ***ongoing employee's*** eligibility for coverage under the ***Plan*** in accordance with the following requirements:

1. An ***employee's hours of service*** during the applicable ***measurement period*** will be considered in determining eligibility for coverage under the ***Plan*** to the extent not preceded by a ***break in service.***

2. Impact on Payroll Periods: For payroll periods that are one ***week***, two ***weeks,*** or semi-monthly in duration, the ***employer*** is permitted to treat as a ***measurement period*** a period that ends on the last day of the payroll period preceding the payroll period that includes the date that would otherwise be the last day of the ***measurement period***, provided that the ***measurement period*** begins on the first day of the payroll period that includes the date that would otherwise be the first day of the ***measurement period***.

   The ***employer*** may also treat as a ***measurement period,*** a period that begins on the first day of the payroll period that follows the payroll period that includes the date that would otherwise be the first day of the ***measurement period,*** provided that the ***measurement period*** ends on the last day of the payroll period that includes the date that would otherwise be the last day of the ***measurement period***.

DEPENDENT(S) ELIGIBILITY

The following describes ***dependent*** eligibility requirements. The ***employer*** will require proof of ***dependent*** status.

1. The term "spouse" means the spouse of the ***employee*** under a legally valid existing marriage in the state in which the ***employee*** resides, unless court ordered separation exists. The term spouse does not include an ***employee's*** domestic partner or common-law spouse.

2. The term "child" means the ***employee's*** natural child, stepchild, legally adopted child, foster child that is placed with the ***employee*** by an authorized agency or court of law, and a child for whom the ***employee*** has been appointed legal guardian, either temporary or permanent, by a court of law, prior to age eighteen (18), provided the child has not reached the end of the month of his or her twenty-sixth (26th) birthday.

3. An eligible child shall also include any other child of an ***employee*** or their spouse who is recognized in a qualified medical child support order (QMCSO), which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan,*** even if the child is not residing in the ***employee's*** household. Such child shall be referred to as an ***alternate recipient***. ***Alternate recipients*** are eligible for coverage regardless of whether the ***employee*** elects coverage for himself. An application for enrollment must be submitted to the ***employer*** for coverage under this ***Plan.*** The ***employer/Plan administrator*** shall establish written procedures for determining whether a medical child support order is a QMCSO and for administering the provision of benefits under the ***Plan*** pursuant to a valid QMCSO. The ***employer/Plan administrator*** reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency. ***Employees*** and ***dependents*** may obtain, without charge, a copy of the ***employer's*** procedures governing qualified medical child support orders (QMCSO).

4. Adopted children, who are less than eighteen (18) years of age at the time of adoption, shall be considered eligible from the date the child is ***placed for adoption.*** ***"Placed for adoption"*** means the date the ***employee*** assumes legal obligation for the total or partial financial support of the child during the adoption process.

5. A child who is unmarried, incapable of self-sustaining employment, and dependent upon the ***employee*** for support due to a mental and/or physical disability, and who was covered under the ***Plan*** prior to reaching the maximum age limit or other loss of ***dependent's*** eligibility, will remain eligible for coverage under this ***Plan*** beyond the date coverage would otherwise be lost.

   Proof of incapacitation must be provided within thirty (30) days of the child's loss of eligibility and thereafter as requested by the ***employer*** or ***claims processor,*** but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:

   A. Cessation of the mental and/or physical disability;

   B. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Eligible ***dependents*** do not include:

1. Other individuals living in the covered ***employee's*** home, but who are not eligible as defined.

2. The legally divorced former spouse of the ***employee.***

3. Any person who is considered a domestic spouse or common-law spouse.

4. Any person who is on active duty in any military service of any country, unless otherwise specified herein.

5. Any person who is covered under the ***Plan*** as an ***employee***.

ENROLLMENT

The benefits of this ***Plan*** are based on a ***benefit year.*** If an ***employee*** or ***dependent*** enrolls for coverage at any time during the ***benefit year,*** the benefits will be calculated on a ***benefit year.***

APPLICATION FOR ENROLLMENT

NEW HIRES

Full-time, Regular Employee on the Monthly Measurement or Look Back Measurement Period Method

A ***full-time, regular employee*** must file a written application with the ***employer*** for coverage hereunder for himself and his eligible ***dependents*** within thirty (30) days of the date coverage would otherwise be effective. Refer to the section entitled, *Effective Date of Coverage.* The ***employee*** shall have the responsibility of timely forwarding to the ***employer*** all applications for enrollment hereunder.

Qualifying Part-time Employee on the Look Back Measurement Period Method

An ***employee*** who has completed the ***initial measurement period*** and during the ***administrative period***, the ***employer*** deems the ***employee*** to have met the eligibility requirements of the ***Plan***, the ***qualifying part-time employee*** must file a written application with the ***employer*** for coverage hereunder for himself and his eligible ***dependents*** during the ***administrative period.*** The ***employee*** shall have the responsibility of timely forwarding to the ***employer*** all applications for enrollment hereunder prior to the end of the ***administrative period.***

FOR ONGOING EMPLOYEES ON THE LOOK BACK MEASUREMENT PERIOD METHOD

Ongoing employees who have completed their ***standard measurement period*** and during the ***administrative period,*** the ***employer*** deems the ***employee*** to have met the eligibility requirements of the ***Plan,*** may elect coverage for himself and any eligible ***dependents*** if he is not covered under the ***Plan,*** or may change benefit plan options for himself or any enrolled ***dependents*** during the ***administrative period***. Enrolled ***employees*** may add or drop coverage for themselves or for enrolled ***dependents*** during the ***administrative period.*** The ***employee*** shall have the responsibility of timely forwarding to the ***employer*** all applications for enrollment hereunder prior to the end of the ***administrative period.***

EMPLOYEE RESPONSIBILITY FOR ENROLLMENT

Employees deemed eligible to enroll for coverage under this ***Plan*** shall bear the responsibility of submitting a properly completed application for enrollment to the ***employer*** within the timeline as determined by the ***Plan.*** The ***employee*** shall have the responsibility of timely forwarding to the ***employer*** all applications for enrollment hereunder.

If the ***employee*** acquires a ***dependent*** after submitting the application for enrollment to the ***employer*** and wishes to enroll the eligible ***dependents,*** the ***employee*** shall submit a revised application for enrollment to the ***employer*** within thirty (30) days of marriage, or the acquiring of children, or birth of a child. The ***employer*** must be notified of any change in a ***dependent's*** loss of eligibility within thirty (30) days of the change***,*** including divorce or legal separation, death, child's reaching the maximum age for eligibility under this ***Plan.*** Forms are available from the ***employer*** for reporting changes in ***dependents'*** eligibility as required.

Once a properly completed application for enrollment has been submitted to the ***employer*** and coverage has become effective, as defined in the section entitled, *Effective Date of Coverage,* the ***employee's*** enrollment option shall remain in effect. The only opportunity to change the enrollment option shall be during the ***administrative period*** for those ***employees*** under the look back ***measurement period*** method; or during the open enrollment for those ***employees*** under the monthly ***measurement period*** method***;*** or upon a Special Enrollment option as defined below. A written waiver of

coverage stating the existence of coverage under another ***creditable coverage*** must have been completed by the ***employee*** in order for the ***employee*** to be considered a Special Enrollee at a later date.

Failure to complete the application for enrollment within thirty (30) days shall result in the *Late Enrollment* provision applying to the individual. An ***alternate recipient*** can be enrolled in the ***Plan*** at any time and shall not be subject to the *Late Enrollment* provision.

EMPLOYEE/SPOUSE ENROLLMENT

Every eligible ***employee*** may enroll eligible ***dependents.*** However, if both the husband and wife are ***employees,*** each individual will be covered as an ***employee.*** An ***employee*** cannot be covered as an ***employee*** and a ***dependent.*** Eligible children may be enrolled as ***dependents*** of one spouse, but not both.

TRANSFER OF COVERAGE

If a husband and wife are both ***employees*** and are covered as ***employees*** under this ***Plan*** and one of them terminates, the terminating spouse and any of the eligible, enrolled children will be permitted to immediately enroll under the remaining ***employee's*** coverage. Such new enrollment will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the ***employee*** or the ***dependent*** of the terminated ***employee.***

SPECIAL ENROLLMENT PERIOD: LOSS OF ELIGIBILITY FOR OTHER COVERAGE

An ***employee*** or ***dependent*** who did not enroll for coverage under this ***Plan*** because he was covered under other group coverage or had health coverage at the time he was initially eligible for coverage under this ***Plan***, may request a special enrollment period if he is no longer eligible for the other coverage. The ***employer*** may require proof of the Special Enrollment event noted below. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

1. Legal separation or divorce;

2. A ***dependent*** child loses eligibility, for example, due to reaching the maximum age.

3. Death of spouse who had the coverage under the other plan;

4. Termination of other employment or reduction in number of hours of other employment;

5. Termination of the other coverage (including exhaustion of COBRA benefits);

6. Cessation of employer contributions toward the other coverage;

7. An individual in an HMO or other arrangement no longer resides, lives or works in the service area.

The end of any extended benefits period which has been provided due to any of the above will also be considered a loss of eligibility.

However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage.)

The ***employee*** or ***dependent*** must request the special enrollment and enroll no later than thirty (30) days from the date of loss of other coverage.

The effective date of coverage as the result of a special enrollment shall be the first day of the first calendar month following the ***employer's*** receipt of the completed enrollment form.

SPECIAL ENROLLMENT PERIOD: DEPENDENT ACQUISITION

An ***employee*** who is not covered under the ***Plan***, but who acquires a new ***dependent*** may request a special enrollment period. The ***employer*** may require proof of the Special Enrollment event noted below. For the purposes of this provision, the acquisition of a new ***dependent*** includes:

1. Marriage;

2. Birth of a ***dependent*** child;

3. Adoption or placement for adoption of a ***dependent*** child.

The ***employee*** must request the special enrollment within thirty (30) days of the acquisition of the ***dependent.***

The effective date of coverage as the result of a special enrollment shall be:

1. In the case of marriage, the first day of the first calendar month following the ***employer's*** receipt of the completed enrollment form;

2. In the case of a ***dependent's*** birth, the date of such birth;

3. In the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

SPECIAL ENROLLMENT PERIOD: MEDICAID AND CHIP ELIGIBILITY

An eligible ***employee,*** or an ***employee's*** eligible ***dependent,*** who is not enrolled under the ***Plan,*** shall be permitted to enroll for coverage hereunder if either of the following conditions are met:

1. Termination of Medicaid or CHIP Coverage: If the ***employee*** or ***dependent*** is covered under a state Medicaid plan under Title XIX of the Social Security Act, or under a state child health plan under Title XXI of the Social Security Act, and coverage of the ***employee*** or ***dependent*** under such other coverage is terminated as a result of loss of eligibility for such coverage.

2. Eligibility for Premium Assistance Under Medicaid or CHIP: If the ***employee*** or ***dependent*** becomes eligible for premium assistance, with respect to coverage under this ***Plan***, under a Medicaid plan or state child health plan.

The ***employee*** or ***dependent*** must submit a completed application for enrollment to the ***employer*** within sixty (60) days of either: (1) termination of coverage under such other coverage, or (2) the date the ***employee*** or ***dependent*** is determined to be eligible for premium assistance. Failure to submit the completed application for enrollment within the designated time shall result in the ***employee's*** or ***dependent's*** forfeiture of this enrollment right and shall be subject to enrolling upon the next open enrollment period sponsored by the ***employer***.

OPEN ENROLLMENT APPLIES TO MONTHLY MEASUREMENT PERIOD METHOD EMPLOYEES ONLY

Open enrollment is the period designated by the ***employer*** during which the ***employee*** may elect coverage for himself and any eligible ***dependents*** if he is not covered under the ***Plan*** and does not qualify for a Special Enrollment as described herein. Enrolled ***employees*** may add or drop coverage for enrolled ***dependents*** during this open enrollment period.

An open enrollment will be permitted once in each ***benefit year*** during a period selected by the ***employer***. Coverage changes shall be effective on the first day of the month following the open enrollment period, provided a properly completed application for enrollment is submitted to the ***employer*** during the designated open enrollment period and must be received by the ***employer*** by the last day of the open enrollment period.

ADMINISTRATIVE PERIOD APPLIES TO THE LOOK BACK MEASUREMENT PERIOD ONLY

The ***administrative period*** is the period designated by the ***employer*** during which the ***employee*** may elect coverage for himself and any eligible ***dependents.*** An ***administrative period*** will follow each ***measurement period. Ongoing employees*** may add or drop coverage for themselves or enrolled ***dependents,*** or may change benefit plan options for himself or any enrolled ***dependents*** during this ***administrative period***.

Coverage changes shall be effective on the first day of the following ***stability period***, provided a properly completed application for enrollment is submitted to the ***employer*** during the designated ***administrative period.***

LATE ENROLLMENT

With the exception of the provisions identified in *Special Enrollment* above, applications for ***employee*** or ***dependent*** coverage which are **not** filed with the ***employer*** within thirty (30) days of meeting the eligibility requirements of the ***Plan*** shall be subject to this late enrollment provision.

Late enrollment applicants shall be eligible to enroll for coverage during the ***Plan's*** annual open enrollment period. Coverage shall become effective the first of the month following the open enrollment period provided a properly completed application for enrollment has been received by the ***employer***. This late enrollment provision shall not apply to an ***alternate recipient.***

WAIVER OF COVERAGE

Employees who elect not to enroll themselves and/or their ***dependents*** must complete a waiver of coverage form. The waiver of coverage must be submitted to the ***employer*** within thirty (30) days of the date coverage would otherwise be effective under this ***Plan.*** If waiver of coverage is due to the existence of other group health coverage upon meeting the ***Plan's*** eligibility requirements, it is the ***employee's*** responsibility to notify the ***employer*** in writing of the existence of the other coverage and this is the reason for waiving coverage upon meeting the eligibility requirements.

EFFECTIVE DATE OF COVERAGE

EMPLOYEE(S) EFFECTIVE DATE

If the ***employee*** does not enroll for coverage within thirty (30) days of meeting the ***Plan's*** eligibility requirements, the ***effective date*** of coverage will be delayed. Refer to the section entitled, *Enrollment.*

NEW HIRES

Full-time, Regular Employees on the Monthly Measurement or Look Back Measurement Period Method

Eligible ***full-time, regular employees,*** as described in, *Eligibility,* are covered under the ***Plan*** on the first of the month following a sixty (60) day waiting period, provided a properly completed enrollment form was submitted to the ***employer.***

If the ***employee*** does not enroll for coverage within thirty (30) days of meeting the ***Plan's*** eligibility requirements, the ***effective date*** of coverage will be delayed. Refer to *Enrollment*.

Part-time Employees on the Monthly Measurement Period Method

In the event a ***part-time employee*** changes employment status to ***full-time, regular employee,*** coverage will be effective on the first day of the month following the date the ***employee*** meets the ***Plan's*** eligibility requirements, provided the ***employee*** worked in a ***part-time*** capacity for the ***employer*** for at least the period of time equal to the ***Plan's*** waiting period, and provided a properly completed application or enrollment to the ***employer.***

Qualifying Part-time Employees on the Look Back Measurement Period

Eligible ***qualifying part-time employees*** will be effective on the first day of the ***qualifying part-time employee's new employee stability period*** provided a properly completed application for enrollment was submitted to the ***employer*** by the end of the ***administrative period.*** A ***qualifying part-time employee*** will remain eligible throughout the ***new employee stability period*** and therefore, covered under the ***Plan,*** to the extent that the ***employee*** remains employed, subject to the ***Plan's break in service*** rules, and *Termination of Coverage* provisions of the ***Plan.***

ONGOING EMPLOYEES ON THE LOOK BACK MEASUREMENT PERIOD METHOD

Eligible ***ongoing employees*** will be effective on the first day of the ***Plan's ongoing employee stability period,*** provided a properly completed application for enrollment was submitted to the ***employer*** by the end of the ***administrative period.***

DEPENDENT(S) EFFECTIVE DATE

Eligible ***dependent(s),*** as described in *Eligibility,* will become covered under the ***Plan*** on the later of the dates listed below, provided the ***employee*** has enrolled them in the ***Plan*** within thirty (30) days of meeting the ***Plan's*** eligibility requirements. If the ***employee*** does not enroll eligible ***dependents*** within thirty (30) days of meeting the ***Plan's*** eligibility requirements, the ***dependents' effective date*** of coverage will be delayed. Refer to *Enrollment*.

1. The date the ***employee's*** coverage becomes effective.

2. The date the ***dependent*** is acquired, provided any required contributions are made and the ***employee*** has applied for ***dependent*** coverage within thirty (30) days of the date acquired.

3. Newborn children shall be covered from birth, regardless of ***confinement,*** provided the ***employee*** has applied for ***dependent*** coverage within thirty (30) days of birth. However, if the ***employee*** already has other ***dependents*** covered under this ***Plan*** when a child is born, additional enrollment for that child will be required.

4. Coverage for a newly adopted child shall be effective on the date the child is ***placed for adoption.***

TERMINATION OF COVERAGE

Except as provided in the ***Plan's*** *Continuation of Coverage* (COBRA) provision, coverage will terminate on the earliest of the following dates:

EMPLOYEE(S) TERMINATION DATE

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health plan.

2. The last day of the month in which the ***employee*** ceases to meet the eligibility requirements of the ***Plan.***

3. The last day of the month in which employment terminates.

4. The date the ***employee*** becomes a ***full-time,*** active member of the armed forces of any country.

5. The date the ***employee*** ceases to make any required contributions.

DEPENDENT(S) TERMINATION DATE

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health plan.

2. The date the ***employee's*** coverage terminates. However, if the ***employee*** remains eligible for the ***Plan,*** but elects to discontinue coverage, coverage may be extended for ***alternate recipients.***

3. The date such person ceases to meet the eligibility requirements of the ***Plan.***

4. The date the ***employee*** ceases to make any required contributions on the ***dependent's*** behalf.

5. The date the ***dependent*** becomes a ***full-time,*** active member of the armed forces of any country.

6. The date the ***Plan*** discontinues ***dependent*** coverage for any and all ***dependents.***

LEAVE OF ABSENCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***employees*** and/or ***dependents,*** when the ***employee*** is on an authorized ***leave of absence*** from the ***employer.*** In no event will coverage continue beyond the end of the twelve (12) calendar week period that next follows the month in which the person last worked as an active ***employee***.

LAYOFF

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***employees*** and/or ***dependents,*** when the ***employee*** is subject to an ***employer layoff.*** In no event will coverage continue beyond the end of the twelve (12) calendar week period that next follows the month in which the person last worked as an active ***employee***.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

An ***employee*** who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under this ***Plan*** while on an approved leave. The duration of leave is contingent upon the reason for the leave as follows:

1. Up to twelve (12) workweeks during a twelve (12) month period:
   - A. for the birth and care of the newborn child of the ***employee***;
   - B. for placement with the ***employee*** of a son or daughter for adoption or foster care;
   - C. to care for an immediate family member (spouse, child, or parent) with a serious health condition; or
   - D. to take medical leave when the ***employee*** is unable to work because of a serious health condition.

For the purposes of this provision, the above shall be referred to as: Other FMLA Qualifying Reasons.

2. Up to twenty-six (26) workweeks during a twelve (12) month period to care for a service member who is undergoing medical treatment, recuperation, or therapy, is otherwise in an outpatient status or is otherwise on temporary disability retired list for a serious ***injury*** or ***illness*** incurred in the line of duty on active duty. For the purpose of the provision, “service member” is defined as a current member of the Armed Forces, including a member of the National Guard or Reserves. This shall be referred to as: Military Caregiver Leave.
3. Up to twelve (12) workweeks during a twelve (12) month period due to a spouse, son, daughter, or parent who is a member of one of the U.S. Armed Force’s Reserve components or National Guard on active duty or is a reservist or member of the National Guard who faces recall to active, federal service by the President if a qualifying exigency exists. This shall be referred to as: Qualifying Exigency Leave.

An ***employee*** who is eligible for FMLA leave is entitled to a combined total of twenty-six (26) workweeks of leave for Military Caregiver Leave and leave for any Other FMLA Qualifying Reason during the same single 12-month period provided that the ***employee*** takes no more than twelve (12) workweeks of leave because of a Qualifying Exigency Leave or for any Other FMLA Qualifying Reason.

Contributions

During this leave, the ***employer*** will continue to pay the same portion of the ***employee's*** contribution for the ***Plan.*** The ***employee*** shall be responsible to continue payment for eligible ***dependent's*** coverage and any remaining ***employee*** contributions. If the covered ***employee*** fails to make the required contribution during a FMLA leave within thirty (30) days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.

Reinstatement

If coverage under the ***Plan*** was terminated during an approved FMLA leave, and the ***employee*** returns to active work immediately upon completion of that leave, ***Plan*** coverage will be reinstated on the date the ***employee*** returns to active work as if coverage had not terminated, provided the ***employee*** makes any necessary contributions and enrolls for coverage within thirty (30) days of his return to active work.

Repayment Requirement

The ***employer*** may require ***employees*** who fail to return from a leave under FMLA to repay any contributions paid by the ***employer*** on the ***employee's*** behalf during an unpaid leave. This repayment will be required only if the ***employee's*** failure to return from such leave is not related to a "serious health condition," as defined in FMLA, or events beyond the ***employee's*** control.

CONTINUATION OF COVERAGE

In order to comply with federal regulations, this ***Plan*** includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Public Health Services Act. This continuation of coverage may be commonly referred to as "COBRA coverage."

The coverage which may be continued under this provision consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes medical, prescription drug, dental and vision benefits as provided under the ***Plan.***

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a ***covered person*** to lose coverage under this ***Plan,*** even if such coverage is not lost immediately, and allow such person to continue coverage beyond the date described in *Termination of Coverage:*

1. Death of the ***employee.***

2. The ***employee's*** termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the ***Plan.***

3. Divorce or legal separation from the ***employee.***

4. The ***employee's*** entitlement to ***Medicare*** benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this ***Plan.***

5. A ***dependent*** child no longer meets the eligibility requirements of the ***Plan.***

6. The last day of leave under the Family Medical Leave Act of 1993.

7. The call-up of an ***employee*** reservist to active duty.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered ***employee,*** or a child's loss of ***dependent*** status, the ***employee*** or ***dependent*** must notify the ***employer*** of that event within sixty (60) days of the event**. Failure to provide such notice to the *employer* will result in the person forfeiting their rights to continuation of coverage under this provision.**

2. The ***employer*** has thirty (30) days to notify the ***claims administrator*** of the qualifying event. Within fourteen (14) days of receiving notice of a qualifying event, the ***claims administrator*** will notify the ***employee*** or ***dependent*** of his rights to continuation of coverage, and what process is required to elect continuation of coverage.

3. After receiving notice, the ***employee*** or ***dependent*** has sixty (60) days to decide whether to elect continued coverage. Each person who was covered under the ***Plan*** prior to the qualifying event, has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the ***employee*** or ***dependent*** chooses to have continued coverage, he must advise the ***employer*** in writing of this choice. The ***employer*** must receive this written notice no later than the last day of the sixty (60) day period. If the election is mailed, the election must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the latter of the following:

   A. The date coverage under the ***Plan*** would otherwise end; or

B. The date the person receives the notice from the ***employer*** of his or her rights to continuation of coverage.

4. Within forty-five (45) days after the date the person notifies the ***employer*** that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continued coverage are to be made monthly, and are due in advance, on the first day each month.

5. The ***employee*** or ***dependent*** must make payments for the continued coverage.

COST OF COVERAGE

1. The ***employer*** requires that ***covered persons*** pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. This must be remitted to the ***employer*** or the ***employer's*** designated representative, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the coverage in force.

2. For purposes of determining monthly costs for continued coverage, a person originally covered as an ***employee*** or as a spouse will pay the rate applicable to an ***employee*** if coverage is continued for himself alone. Each child continuing coverage independent of the family unit will pay the rate applicable to an ***employee.***

WHEN CONTINUATION COVERAGE BEGINS

When continuation coverage is elected and the contributions paid within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for ***dependents*** acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the ***Plan.***

Since a reduction in employment hours is a qualifying event under this provision, any continuation of coverage granted by the ***employer*** (***leave of absence, layoff,*** shall run simultaneously with the continuation of coverage provided under this provision (COBRA).

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A spouse or ***dependent*** child newly acquired during continuation coverage is eligible to be enrolled as a ***dependent.*** The standard enrollment provision of the ***Plan*** applies to enrollees during continuation coverage. A ***dependent*** acquired and enrolled after the original qualifying event, other than a child born to or ***placed for adoption*** with a covered ***employee*** during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

SUBSEQUENT QUALIFYING EVENTS

Once covered under continuation coverage, it is possible for a second qualifying event to occur, including:

1. Death of an ***employee.***

2. Divorce or legal separation from an ***employee.***

3. ***Employee's*** entitlement to ***Medicare.***

4. The child's loss of ***dependent*** status.

If one of these subsequent qualifying events occurs, a ***dependent*** may be entitled to a second continuation period. This period will in no event continue beyond thirty-six (36) months from the date of the first qualifying event.

Only a person covered prior to the original qualifying event or a child born to or ***placed for adoption*** with a covered ***employee*** during a period of COBRA continuation is eligible to continue coverage again as the result of a subsequent qualifying event. Any other ***dependent*** acquired during continuation coverage is not eligible to continue coverage as the result of a subsequent qualifying event.

END OF CONTINUATION

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen (18) months from the date continuation began because of a reduction of hours or termination of employment of the ***employee.***

2. Thirty-six (36) months from the date continuation began for ***dependents*** whose coverage ended because of the death of the ***employee,*** divorce or legal separation from the ***employee,*** or the child's loss of ***dependent*** status.

3. The end of the period for which contributions are paid if the ***covered person*** fails to make a payment on the date specified by the ***employer.***

4. The date coverage under this ***Plan*** ends and the ***employer*** offers no other group health benefit plan.

5. The date the ***covered person*** first becomes entitled to ***Medicare*** after the original date of the ***covered person's*** election of continuation coverage.

6. The date the ***covered person*** first becomes covered under any other group health plan after the original date of the ***covered person's*** election of continuation coverage.

EXTENSION FOR DISABLED INDIVIDUALS

A person who is ***totally disabled*** may extend continuation coverage from eighteen (18) months to twenty-nine (29) months. The person must be disabled for Social Security purposes at the time of the qualifying event or within sixty (60) days thereafter. The disabled person must submit proof of the determination of disability by the Social Security Administration to the ***employer*** within the initial eighteen (18) month continuation coverage period and no later than sixty (60) days after the Social Security Administration's determination. The disabled person and the family members who were covered prior to the qualifying event are eligible for up to twenty-nine (29) months of continuation of coverage. The ***employer*** may charge 150% of the contribution during the additional eleven (11) months of continuation of coverage. Extended coverage will end the month that begins thirty (30) days after the person is no longer considered disabled.

MILITARY MOBILIZATION

If an ***employee*** is called for active duty by the United States Armed Services (including the Coast Guard), the National Guard or the Public Health Service, the ***employee*** may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the ***employee*** may not be required to pay more than the ***employee's*** share, if any, applicable to that coverage. If the leave is more than thirty-one (31) days, then the ***employer*** may require the ***employee*** to pay no more than 102% of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or

2. A period beginning on the day that the leave began and ending on the day after the ***employee*** fails to return to employment within the time allowed.

Whether or not the individual elects continuation of coverage under USERRA, upon return from uniformed service, the ***employee's*** coverage will be reinstated the date of return to work, provided the uniformed service member was released under honorable conditions, and returns to work within the following timelines:

1. Following completion of the military service for a leave of less than thirty-one (31) days, upon the first full regularly scheduled work period after the expiration of eight (8) hours after a period allowing for the safe transportation of the person from the place of service to the person's residence.

2. Within fourteen (14) days of completing military service for a leave of thirty-one (31) days to one hundred eighty (180) days;

3. Within ninety (90) days of completing military service for a leave of more than one hundred eighty (180) days.

The ***Plan*** shall be reinstated without exclusions other than for a period or exclusions that would have applied even if there had been no absence for uniformed service.

CLAIM FILING PROCEDURE

FILING A CLAIM

1. A claim form is to be completed on each covered family member at the beginning of the ***benefit year*** and for each claim involving an ***injury***. Appropriate claim forms are available from the Human Resources Department.

2. All bills submitted for benefits must contain the following:

   A. Name of patient.
   B. Patient's date of birth.
   C. Name of ***employee.***
   D. Address of ***employee.***
   E. Name of ***employer.***
   F. Name, address and tax identification number of provider.
   G. ***Employee*** Social Security number.
   H. Date of service.
   I. Diagnosis.
   J. Description of service and procedure number.
   K. Charge for service.
   L. The nature of the accident, Injury or Illness being treated.

3. Properly completed claims not submitted within one (1) year of the date of incurred liability will be denied.

The ***covered person*** may ask the provider to submit the bill directly to the ***claims processor,*** or the ***covered person*** may file the bill with a claim form. However, it is ultimately the ***covered person's*** responsibility to make sure the claim has been filed for benefits.

Proof of Payment of Deductible

To obtain benefits under this ***Plan,*** the ***covered person*** must submit proof to the ***claims processor*** that the deductible for the ***benefit year*** has been incurred. Proof will include an itemized bill on the provider's letterhead or statement and the diagnosis.

FOREIGN CLAIMS

In the event a ***covered person*** incurs a ***covered expense*** in a foreign country, the ***covered person*** shall be responsible for providing the following to the ***claims processor*** before payment of any benefits due are payable:

1. The claim form, provider invoice and any other documentation required to process the claim must be submitted in the English language.

2. The charges for services must be converted into dollars.

3. A current conversion chart validating the conversion from the foreign country's currency into dollars.

NOTICE OF CLAIM

A claim for benefits should be submitted to the ***claims processor*** within ninety (90) days after the occurrence or commencement of any services covered by the ***Plan,*** or as soon thereafter as reasonably possible. Benefits are based on the ***Plan's*** provisions at the time the expenses were incurred.

Failure to file a claim within the time provided shall not invalidate or reduce any claim if it shall be shown that: (1) it was not reasonably possible to file a claim within that time; (2) and that such claim was furnished as soon as possible, but no later than one (1) year after the loss occurs or commences, unless the claimant is legally incapacitated.

Notice given by or on behalf of a ***covered person*** or his beneficiary, if any, to the ***Plan administrator*** or to any authorized agent of the ***Plan*** with information sufficient to identify the ***covered person,*** shall be deemed notice of claim.

PAYMENT OF BENEFITS

After a claim has been submitted to the ***claims processor,*** if additional information is needed for payment of the claim, the ***claims processor*** will request the same. The ***claims processor*** will approve, partially approve, or deny the claim within thirty (30) days after all necessary information is received by the ***claims processor*** to determine the validity of the claim. This time period may be extended for fifteen (15) days if it is necessary because of matters beyond the ***Plan's*** control, and if the ***Plan*** notifies the ***covered person*** of those circumstances and the expected date of decision before the end of the thirty (30) day period. This Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. The ***employee*** will be allowed up to forty-five (45) calendar days from receipt of the Notice of Extension to provide the additional information. The ***Plan*** will then make a claim determination within a reasonable period but not later than fifteen (15) calendar days from the date the ***Plan*** receives the additional information.

If the services of a ***preferred provider*** are used, ***Plan*** benefits are payable directly to the provider of service. If the services of a ***nonpreferred provider*** are used, benefits are payable to the ***covered person*** whose ***illness*** or ***injury,*** or whose ***dependent's illness*** or ***injury,*** is the basis of claim under this ***Plan,*** unless the ***covered person*** has made an assignment of benefits to the provider of service.

In the event a claim for benefits under the ***Plan*** is denied in whole or in part, the ***covered person*** will receive written notification stating the required information including the review procedure, in the same fashion as reimbursement for a claim, in a manner calculated to be understood by the ***covered person.*** A claim worksheet will be provided by the ***claims processor*** showing the calculation of the total amount payable, charges not payable, and the reason.

APPEALING A CLAIM

Review Procedures

A ***covered person,*** or the ***covered person's*** representative may request a review of the claim denial by making written request to the ***claims processor*** within one-hundred-eighty (180) days of receipt of the notice of denial. Written notice for review should:

1. State the reasons the ***covered person*** feels the claim should not have been denied; and

2. Include any additional documentation which the ***covered person*** believes supports the claim.

On receipt of written request for review of a claim, the ***claims processor*** will review the claim and furnish copies to the ***employer*** of all documents and all reasons and facts relative to the decision. An ***employee,*** or his authorized representative, may examine all pertinent documents which the ***claims processor*** may have, excluding any medical records of a confidential nature, and submit an opinion in writing of the issues and his comments to the ***employer.***

Decision on Review

Decision by the ***employer*** will be made within sixty (60) days of receipt of the written opinion unless special circumstances require more time, then the decision shall be rendered as soon as possible, but no later than one-hundred-twenty (120) days after receipt of the ***covered person's*** request for review. This decision will also be delivered to the ***covered person*** in writing, setting forth specific reasons for the decision and specific references to the pertinent ***Plan*** provisions upon which the decision is based. The decision is final.

INTERNAL AND EXTERNAL APPEAL PROCESS

The ***Plan*** shall maintain an Internal Appeals and an External Appeals Process in accordance with the following:

Internal Appeals Process

1. Clarification of "Adverse Benefit Determination": The scope of an "adverse benefit determination" eligible for internal claims and appeals includes a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time).

2. Full and Fair Review: The ***Plan*** shall provide a ***covered person*** (free of charge) any new or additional evidence considered, relied upon or generated by the ***Plan*** in connection with a claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the ***covered person*** to respond to such new evidence or rationale before a final adverse benefit determination is made.

3. Avoidance of Any Conflict of Interest: The ***Plan*** must ensure any decisions related to hiring, compensation, termination, promotion or other similar matters with respect to any individual in the claims decision process, such as a ***claims processor*** or medical expert, may not be based on the likelihood that the individual will support the denial of benefits.

4. Notices - Content Requirements: Any notice of an adverse benefit determination or final internal adverse benefit determination must include the following:

   A. Claim Identification. Information sufficient to identify the claim involved, including the date of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

   B. Rationale for Denial. The reason or reasons for an adverse benefit determination including the denial code and its corresponding meaning and a description of the standard(s) applied in denying the claim. A notice of a final internal adverse benefit determination must also include a discussion of the decision.

   C. Claims and Appeal Procedures. The ***Plan*** must provide a description of the available internal and external review processes (including information on how to initiate an appeal).

   D. Consumer Assistance. The ***Plan*** must disclose the availability of and contact information for any outside applicable office to assist ***covered persons*** with the claims, appeals, and external review processes.

5. Deemed Exhaustion of Internal Claims and Appeals Processes: If the ***Plan*** fails to strictly adhere to all requirements of the Internal Claims and Appeals, a ***covered person*** will be deemed to have exhausted the internal claims and appeals process, regardless of whether the ***Plan*** asserts that it has substantially complied, and the ***covered person*** may initiate any available external review process or remedies available at law.

Standard External Appeals Process

1. Request for External Review: The ***Plan*** will allow a ***covered person*** to file a request for an external review if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth (5th) month following the receipt of the notice. (For example, if the date of receipt of the notice is October 30th, because there is no February 30th, the request must be filed by March 1st). If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary Review: Within five (5) business days following the date of receipt of the external review request, the ***Plan*** will complete a preliminary review of the request to determine whether:

A. The ***covered person*** is or was covered under the ***Plan*** at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the ***Plan*** at the time the health care item or service was provided;

B. The adverse benefit determination or the final adverse benefit determination does not relate to the ***covered person's*** failure to meet the requirements for eligibility under the terms of the ***Plan***.

C. The ***covered person*** has exhausted the ***Plan's*** internal appeal process.

D. The ***covered person*** has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the ***Plan*** will issue a notification in writing to the ***covered person*** or the ***covered person's*** authorized representative. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272). If the request is not complete, such notification will include the information or materials needed to make the request complete and the ***Plan*** will allow a ***covered person*** to perfect the request for external review within the four (4) month filing period or within the forty-eight (48) hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization (IRO): The ***Plan*** will assign an independent review organization (IRO) that is accredited by URAC or by similar nationally recognized accrediting organization to conduct the external review. The ***Plan*** will also take action to ensure against bias and to ensure independence. To do this, the ***Plan*** will contract with at least three (3) IROs for assignments under the ***Plan*** and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). An IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Minimum Standards for IRO Contract: A contract between the ***Plan*** and an IRO must provide the following:

A. The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the ***Plan.***

B. The assigned IRO will timely notify the ***covered person*** in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the ***covered person*** may submit in writing to the assigned IRO within ten (10) business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days.

C. Within five (5) business days after the date of assignment of the IRO, the ***Plan*** must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the ***Plan*** to timely provide the documents and information must not delay the conduct of the external review. If the ***Plan*** fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one (1) business day after making the decision, the IRO must notify the ***covered person*** and the ***Plan***.

D. Upon receipt of any information submitted by the ***covered person***, the assigned IRO must within one (1) business day forward the information to the ***Plan***. Upon receipt of any such information, the ***Plan*** may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the ***Plan*** must not delay the external review. The external review may be terminated as a result of the reconsideration only if the ***Plan*** decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one (1) business day after making such a decision, the ***Plan*** must provide written notice of its decision to the ***covered person*** and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the ***Plan***.

E. The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the ***Plan's*** internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the PHS Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

i. The ***covered person***'s medical records;
ii. The attending health care professional's recommendation;
iii. Reports from appropriate health care professionals and other documents submitted by the plan or issuer, ***covered person***, or ***covered person***'s treating provider;
iv. The terms of the ***covered person***'s ***Plan*** to ensure that the IRO's decision is not contrary to the terms of the ***Plan***, unless the terms are inconsistent with applicable law;
v. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
vi. Any applicable clinical review criteria developed and used by the ***Plan***, unless the criteria are inconsistent with the terms of the ***Plan*** or with applicable law; and
vii. The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

F. The assigned IRO must provide written notice of the final external review decision within forty-five (45) days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the ***covered person*** and the ***Plan***.

G. The assigned IRO's decision notice will contain:

i. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
ii. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
iii. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
iv. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the ***covered person***;
v. A statement that judicial review may be available to the ***covered person***; and
vi. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHA Act section 2793.

H. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the ***covered person***, ***Plan***, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

5. Reversal of ***Plan's*** Decision: Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the ***Plan*** immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Reviews

1. Request for Expedited External Review: The ***Plan*** must allow a ***covered person*** to make a request for an expedited external review with the ***Plan*** at the time the ***covered person*** receives:

A. An adverse benefit determination if the adverse benefit determination involves a medical condition of the ***covered person*** for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the life or health of the ***covered person*** or would jeopardize the ***covered person***'s ability to regain maximum function and the ***covered person*** has filed a request for an expedited internal appeal; or

B. A final internal adverse benefit determination, if the ***covered person*** has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the ***covered person*** or would jeopardize the ***covered person***'s ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the ***covered person*** received ***emergency*** services, but has not been discharged from a ***facility***.

2. Preliminary Review: Immediately upon receipt of the request for expedited external review, the ***Plan*** must determine whether the request meets the reviewability requirements set forth in paragraph 2 above for standard external review. The ***Plan*** must immediately send a notice that meets the requirements set forth in paragraph 2 above for standard external review to the ***covered person*** of its eligibility determination.

3. Referral to Independent Review Organization: Upon a determination that a request is eligible for external review following the preliminary review, the ***Plan*** will assign an IRO pursuant to the above requirements for standard review. The ***Plan*** must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the ***Plan's*** internal claims and appeals process.

4. Notice of Final External Review Decision: The ***Plan's*** contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the ***covered person***'s medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the ***covered person*** and the ***Plan***.

COORDINATION OF BENEFITS

The *Coordination of Benefits* provision is intended to prevent duplication of benefits. It applies when the ***covered person*** is also covered by any Other Plan(s). When more than one coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plan, pays a reduced benefit. When coordination of benefits occurs, the total benefit payable by all plans will not exceed 100% of "allowable expenses." Only the amount paid by this ***Plan*** will be charged against the ***maximum benefit.***

The *Coordination of Benefits* provision applies whether or not a claim is filed under the Other Plan(s). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

"Allowable Expenses" means any reasonable, necessary, and customary expenses incurred while covered under this ***Plan,*** part or all of which would be covered under this ***Plan***. Allowable Expenses do not include expenses contained in the "Exclusions" sections of this ***Plan.***

When this ***Plan*** is secondary, "Allowable Expense" will include any deductible or ***coinsurance*** amounts not paid by the Other Plan(s).

When this ***Plan*** is secondary, "Allowable Expense" shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the ***covered person*** for the difference between the provider's contracted amount and the provider's regular billed charge.

"Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for ***covered persons*** in a group, whether on an insured or uninsured basis, including, but not limited to, hospital indemnity benefits and hospital reimbursement-type plans;

2. Hospital or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;

3. A licensed Health Maintenance Organization (HMO);

4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;

5. Any coverage under a government program and any coverage required or provided by any statute;

6. Group automobile insurance;

7. Individual automobile insurance coverage;

8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;

9. Any plan or policies funded in whole or in part by an ***employer,*** or deductions made by an ***employer*** from a person's compensation or retirement benefits;

10. Labor/management trustee, union welfare, employer organization, or employee benefit organization plans.

"This ***Plan"*** shall mean that portion of the ***employer's Plan*** which provides benefits that are subject to this provision.

"Claim Determination Period" means a ***benefit year*** or that portion of a ***benefit year*** during which the ***covered person*** for whom a claim is made has been covered under this ***Plan.***

AUTOMOBILE LIMITATIONS

When medical payments are available under vehicle insurance, the ***Plan*** shall pay excess benefits only, without reimbursement for vehicle plan deductibles. The ***Plan*** shall always be considered the secondary carrier regardless of the individual's election under personal injury protection with the auto insurance carrier.

EFFECT ON BENEFITS

This provision shall apply in determining the benefits for a ***covered person*** for each claim determination period for the Allowable Expenses. If this ***Plan*** is secondary, the benefits that would be payable under this ***Plan*** for each claim in the absence of this provision shall be calculated and reduced by the benefits payable under all other plans for the expenses covered in whole or in part by this ***Plan***.

If the rules set forth below would require this ***Plan*** to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this ***Plan***.

ORDER OF BENEFIT DETERMINATION

Each plan will make its claim payment according to the following order of benefit determination:

1. No Coordination of Benefits Provision
   If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).

2. Member/Dependent
   The plan which covers the claimant as a member (or named insured) pays as though no Other Plan existed. Remaining ***covered expenses*** are paid under a plan which covers the claimant as a ***dependent.***

3. Dependent Children of Parents not Separated or Divorced
   The plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.

4. Dependent Children of Separated or Divorced Parents
   When parents are separated or divorced, the birthday rule does not apply, instead:

   A. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent pays fourth.
   B. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody pays fourth.

5. Active/Inactive
   The plan covering a person as an active (not laid off or retired) ***employee,*** or as that person's ***dependent*** pays first. The plan covering that person as a laid off or retired ***employee,*** or as that person's ***dependent*** pays second.

6. Limited Continuation of Coverage

If a person is covered under another group health plan, but is also covered under this ***Plan*** for continuation of coverage due to the Other Plan's exclusions, the Other Plan shall be primary for all ***covered expenses*** which are not related to the exclusions.

7. Longer/Shorter Length of Coverage
If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

COORDINATION WITH MEDICARE

Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for ***Medicare*** Part A at no cost. Participation in ***Medicare*** Part B is available to all individuals who make application and pay the full cost of the coverage.

1. When an ***employee*** becomes entitled to ***Medicare*** coverage and is still ***actively at work,*** the ***employee*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

2. When a ***dependent*** becomes entitled to ***Medicare*** coverage and the ***employee*** is still ***actively at work,*** the ***dependent*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

3. If the ***employee*** and/or ***dependent*** is also enrolled in ***Medicare,*** this ***Plan*** shall pay as the primary plan. ***Medicare*** will pay as secondary plan.

4. If the ***employee*** and/or ***dependent*** elect to discontinue health coverage under this ***Plan*** and enroll under the ***Medicare*** program, no benefits will be paid under this ***Plan.*** ***Medicare*** will be the only payor.

This section is subject to the standard terms of the ***Medicare*** Secondary Payor laws and regulations, including but not limited to, determination of first and second payor for a person with End Stage Renal Disease, or a person eligible for Medicare due to disability. Any changes in these related laws and regulations will apply to the provisions of this section.

LIMITATIONS ON PAYMENTS

In no event shall the ***covered person*** recover under this ***Plan*** and all Other Plan(s) combined more than the total Allowable Expenses offered by this ***Plan*** and the Other Plan(s). Nothing contained in this section shall entitle the ***covered person*** to benefits in excess of the total ***maximum benefits*** of this ***Plan*** during the claim determination period. The ***covered person*** shall refund to the ***employer*** any excess it may have paid.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this *Coordination of Benefits* provision, the ***Plan*** may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information with respect to any ***covered person.*** Any person claiming benefits under this ***Plan*** shall furnish to the ***employer*** such information as may be necessary to implement the *Coordination of Benefits* provision.

FACILITY OF BENEFIT PAYMENT

Whenever payments which should have been made under this ***Plan*** in accordance with this provision have been made under any Other Plan, the ***employer*** shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this ***Plan*** and, to the extent of such payments, the ***employer*** shall be fully discharged from liability.

SUBROGATION/REIMBURSEMENT

The ***Plan*** maintains the right to seek reimbursement on its own behalf: the right of subrogation. The ***Plan*** also reserves the right to reimbursement upon a ***covered person's*** (a covered ***employee*** or a covered dependent) receipt of settlement, judgment, or award: the right of reimbursement. The ***Plan*** reserves the right of recovery, either by subrogation or reimbursement, for ***covered expenses*** payable by the ***Plan*** which are a result of ***illness*** or ***injury***. The ***Plan*** shall be reimbursed from the first monies recovered as the result of judgment, settlement or otherwise. (This is known as "Pro tanto" subrogation.) This right includes the ***Plan's*** right to receive reimbursement from uninsured or underinsured motorist coverage and no-fault coverage.

Accepting benefits from this ***Plan*** automatically assigns to it any rights the ***covered person*** may have to recover benefits from any party, including an insurer or another group health program. This right of recovery allows the ***Plan*** to pursue any claim which the ***covered person*** may have against any party, group health program or insurer, whether or not the ***covered person*** chooses to pursue that claim. This includes a right to recover from no-fault auto insurance carriers in a situation where no third party may be liable, or from any uninsured or underinsured motorist coverage where the recovery was triggered by the actions of a party which caused or contributed to the payment of benefits under this ***Plan.*** This also includes a right to recover from amounts the ***covered person*** received from workers' compensation, whether by judgment or settlement, where the ***Plan*** has paid benefits prior to a determination that the medical expenses arose out of and in the course of employment. Payment by workers' compensation will be presumed to mean that such a determination has been made.

If a ***covered person*** is involved in an automobile accident, or suffers an ***illness*** or ***injury*** that was due to the action or inaction of any party, the ***Plan*** may advance payment in order to prevent any financial hardship to the ***covered person.*** Acceptance of ***Plan*** benefits acknowledges (1) the obligation of the ***covered person*** to help the ***Plan*** to recover benefits it has paid out on behalf of the ***covered person,*** and (2) to provide the ***Plan*** with information concerning: any automobile insurance, any other group health program which may be obligated to pay benefits on behalf of the ***covered person,*** and the insurance of any other party involved. The ***covered person*** is required to cooperate fully in the ***Plan's*** exercise of its right to recovery and the ***covered person*** cannot do anything to prejudice those rights. Such cooperation is required as a condition of receiving benefits under the ***Plan.*** The ***Plan administrator*** may refuse to pay benefits, or cease to pay benefits, on behalf of a ***covered person*** who fails to sign any document deemed by the ***Plan administrator*** to be relevant to protecting its subrogation rights or fails to provide relevant information when requested. The term information includes any documents, insurance policies, police reports, or any reasonable request by the ***claims processor*** or ***Plan administrator*** to enforce the ***Plan's*** rights.

Whether the ***covered person*** or the ***Plan*** makes a claim directly against any party, group health program or insurance company for the benefit payments made on behalf of a ***covered person*** by the ***Plan,*** the ***Plan*** has a lien on any amount the ***covered person*** recovers or could recover from any party, insurance company, or group health program whether by judgment, settlement, or otherwise, and whether or not designated as payment for medical expenses. This lien shall remain in effect until the ***Plan*** acknowledges and agrees upon payment to the ***Plan*** and releases its lien. The lien may not be for an amount greater than the amount of benefits paid under the ***Plan.***

Failure to reimburse the ***Plan*** for ***covered expenses*** paid by the ***Plan*** that were also paid by a third party otherwise responsible shall result in a reduction of future claim benefits of a ***covered person*** up to the aggregate amount the ***Plan*** has paid.

The ***Plan administrator*** has delegated to the ***claims processor*** the right to perform ministerial functions required to assert the ***Plan's*** rights; however, the ***Plan administrator*** shall retain discretionary authority with regard to asserting the ***Plan's*** recovery rights.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The ***Plan*** is administered through the Human Resources Department of the ***employer.*** The ***employer*** is the ***Plan administrator.*** The ***Plan administrator*** shall have full charge of the operation and management of the ***Plan.*** The ***employer*** has retained the services of an independent ***claims processor*** experienced in claims review.

The ***employer*** is the named fiduciary of the ***Plan.*** As fiduciary, the ***employer*** maintains discretionary authority to review all denied claims for benefits under the ***Plan*** with respect to which it has been designated named fiduciary, including, but not limited to, the denial of certification of the ***medical necessity*** of ***hospital*** or medical services, supplies and treatment, to interpret the terms of the ***Plan,*** and to determine eligibility for and entitlement to ***Plan*** benefits in accordance with the terms of the ***Plan.***

ASSIGNMENT

The ***Plan*** will pay benefits under this ***Plan*** to the ***employee*** unless payment has been assigned to a ***hospital, physician,*** or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the ***Plan*** unless the ***claims processor*** is notified in writing of such assignment prior to payment hereunder. This ***Plan*** will pay benefits to the responsible party of an ***alternate recipient*** as designated in a qualified medical child support order.

Preferred providers normally bill the ***Plan*** directly. If services, supplies or treatment has been received from such a provider, benefits are automatically paid to that provider. The ***covered person's*** portion of the ***negotiated rate,*** after the ***Plan's*** payment, will then be billed to the ***covered person*** by the ***preferred provider.***

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible ***covered person*** is entitled to receive benefits under this ***Plan.*** Such right to benefits is not transferable.

CLERICAL ERROR

For termination of coverage for an ***employee's*** coverage or ***dependent*** coverage, the ***employer*** may make an adjustment of contributions on the next monthly billing of up to ninety (90) days retroactively after the error or delay is discovered and submitted to the ***claims processor.*** No adjustments will be made in coverage or contributions for more than ninety (90) days retroactively.

For implementation of coverage for an ***employee*** whose application for enrollment was not submitted to the ***claims processor*** by the ***employer*** within thirty (30) days of the eligibility date, the ***employee*** will be effective coincident with or on the first of the month following receipt by the ***claims processor*** of a properly completed application for enrollment.

For implementation of coverage for ***dependent*** coverage: In the event that ***employer*** payroll deductions for family coverage occurred and the application for enrollment of ***dependent*** coverage was not submitted to the ***claims processor,*** the ***employee*** and ***dependents*** shall be enrolled for coverage retroactively to the applicable date of coverage, provided proof of payroll deductions are submitted to the ***claims processor*** with the application for enrollment. ***Employees*** and ***dependents*** will be added retroactive to the original effective date following the completion of any waiting period. In the event that payroll records are not provided, ***dependents*** may be added at the next open enrollment period, and the ***employee's*** coverage will be effective first of the month following receipt of the completed application for enrollment by the ***claims processor.***

CONFORMITY WITH STATUTE(S)

Any provision of the ***Plan*** which is in conflict with statutes which are applicable to this ***Plan*** is hereby amended to conform to the minimum requirements of said statute(s).

EFFECTIVE DATE OF THE PLAN

The original ***effective date*** of this ***Plan*** is October 1, 2015.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this ***Plan*** shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a ***hospital*** or to make a free choice of the attending ***physician*** or ***professional provider.*** However, benefits will be paid in accordance with the provisions of this ***Plan,*** and the ***covered person*** will have higher out-of-pocket expenses if the ***covered person*** uses the services of a ***nonpreferred provider.***

INCAPACITY

If, in the opinion of the ***employer,*** a ***covered person*** for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the ***Plan*** of the qualification of a guardian or personal representative for his estate, the ***employer*** may on behalf of the ***Plan,*** at his discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the ***Plan's*** obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the ***employer*** or by the ***employee*** covered under this ***Plan*** shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this ***Plan*** or be used in defense to a claim unless they are contained in writing and signed by the ***employer*** or by the ***covered person,*** as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the benefits from the ***Plan*** prior to the expiration of sixty (60) days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the ***Plan.*** No such action shall be brought after the expiration of two (2) years from the date the expense was ***incurred,*** or one (1) year from the date a completed claim was filed, whichever occurs first.

LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the ***employer*** shall not be liable for any obligation of the ***covered person incurred*** in excess thereof. The ***employer*** shall not be liable for the negligence, wrongful act, or omission of any ***physician, professional provider, hospital,*** or other institution, or their employees, or any other person. The liability of the ***Plan*** shall be limited to the reasonable cost of ***covered expenses*** and shall not include any liability for suffering or general damages.

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the ***Plan administrator*** is unable to locate the ***covered person*** to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the ***covered person*** for the forfeited benefits within the time prescribed in *Claim Filing Procedure.*

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

The ***Plan*** will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a State plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a ***covered person*** or in determining or making any payment of benefits to that individual. The ***Plan*** will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and this ***Plan*** has a legal liability to make payments for the same services, supplies or treatment, payment under the ***Plan*** will be made in accordance with any State law which provides that the State has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the ***Plan.***

MISREPRESENTATION

If the ***covered person*** or anyone acting on behalf of a ***covered person*** makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the ***Plan,*** or otherwise misleads the ***Plan,*** the ***Plan*** shall be entitled to recover its damages, including legal fees, from the ***covered person,*** or from any other person responsible for misleading the ***Plan,*** and from the person for whom the benefits were provided. Any material misrepresentation on the part of the ***covered person*** in making application for coverage, or any application for reclassification thereof, or for service there under shall render the coverage under this ***Plan*** null and void.

In the event an ***employee*** enrolled in the ***Plan*** fraudulently or with intentional misrepresentation of a material fact, the coverage under this ***Plan*** shall be terminated upon a thirty (30) day advance, written notice to the ***employee.***

PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN

The ***Plan,*** at its own expense, shall have the right to require an examination of a person covered under this ***Plan*** when and as often as it may reasonably require during the pendency of a claim.

PLAN IS NOT A CONTRACT

The ***Plan*** shall not be deemed to constitute a contract between the ***employer*** and any ***employee*** or to be a consideration for, or an inducement or condition of, the employment of any ***employee.*** Nothing in the ***Plan*** shall be deemed to give any ***employee*** the right to be retained in the service of the ***employer*** or to interfere with the right of the ***employer*** to terminate the employment of any ***employee*** at any time.

PLAN MODIFICATION AND AMENDMENT

The ***employer*** may modify or amend the ***Plan*** from time to time at its sole discretion, and such amendments or modifications which affect ***covered persons*** will be communicated to the ***covered persons.*** Any such amendments shall be in writing, setting forth the modified provisions of the ***Plan,*** the ***effective date*** of the modifications, and shall be signed by the ***employer's*** designee.

An amendment to the ***Plan*** may be retroactively effective, but shall not adversely affect the rights of ***covered persons*** under this ***Plan*** for ***covered expenses*** provided after the effective date of the amendment but before the amendment is adopted.

Such modification or amendment shall be duly incorporated in writing into the master copy of the ***Plan*** on file with the ***employer,*** or a written copy thereof shall be deposited with such master copy of the ***Plan.***

PLAN TERMINATION

The ***employer*** reserves the right to terminate the ***Plan,*** in whole or in part, at any time. Upon termination, the rights of the ***covered persons*** to benefits are limited to claims ***incurred*** up to the date of termination. Any termination of the ***Plan*** will be communicated to the ***covered persons.***

Upon termination of this ***Plan,*** all claims ***incurred*** prior to termination, but not submitted to either the ***employer*** or ***claims processor*** within three (3) months of the ***effective date*** of termination of this ***Plan,*** will be excluded from any benefit consideration.

PRIVACY RULE

It is intended for the ***Plan*** to be in compliance with the requirements of § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy Rule" and § 164.504 (f) is referred to as "the 504" provisions") by establishing the extent to which the ***Plan sponsor*** will receive, use and /or disclose Protected Health Information (PHI).

Designation Of Person/Entity To Act On Plan's Behalf

The ***Plan*** has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the ***Plan*** designates the Human Resources Manager to take all actions required to be taken by the ***Plan*** in connection with the HIPAA Privacy Rule.

Disclosure of Protected Health Information (PHI) to the Plan Sponsor – Required Certification of Compliance by Plan Sponsor

1. Except as provided below with respect to the ***Plan's*** disclosure of summary health information, the ***Plan*** will (a) disclose PHI to the ***Plan Sponsor*** or (b) provide for or permit the disclosure of PHI to the ***Plan Sponsor*** by the ***claims processor*** with respect to the ***Plan***, *only if* the ***Plan*** has received a certification (signed on behalf of the ***Plan Sponsor***) that:

    A. The Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the ***Plan Sponsor***;

    B. The ***Plan Sponsor*** agrees to comply with the ***Plan*** provisions in relation to HIPAA Privacy Rules.

Permitted Disclosure of Individuals' Protected Health Information (PHI) to the Plan Sponsor

1. The ***Plan*** (and any business associates acting on behalf of the ***Plan***), or any health insurance issuer servicing the ***Plan*** will disclose individuals' PHI to the ***Plan Sponsor*** only to permit the ***Plan Sponsor*** to carry out plan administration functions.

2. All disclosures of the PHI of the ***Plan's covered persons*** by the ***Plan's*** business associate, or health insurance issuer to the ***Plan Sponsor*** will comply with the restrictions and requirements set forth herein.

3. The ***Plan*** (and any business associate acting on behalf of the ***Plan***), may not, and may not permit a health insurance issuer to, disclose individuals' PHI to the ***Plan Sponsor*** for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the ***Plan Sponsor***.

4. The ***Plan Sponsor*** will not use or further disclose individuals' PHI other than as described in the Plan Documents.

5. The ***Plan Sponsor*** will ensure that any agent(s), including a subcontractor, to whom it provides individuals' PHI received from the ***Plan*** (or from the ***Plan's*** health insurance issuer), agrees to the same restrictions and conditions that apply to the ***Plan Sponsor*** with respect to such PHI.

6. The ***Plan Sponsor*** will not use or disclose individuals' PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the ***Plan Sponsor.***

7. The ***Plan Sponsor*** will report to the **Plan** any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in the Plan Document of which the ***Plan Sponsor*** becomes aware.

Disclosure of Individuals' Protected Health Information - Disclosure by the Plan Sponsor

1. The ***Plan Sponsor*** will make the PHI of the individual who is the subject of the PHI available to such individual.

2. The ***Plan Sponsor*** will make individuals' PHI available for amendment and incorporate any amendments to individuals' PHI.

3. The ***Plan Sponsor*** will make and maintain an accounting so that it can make available those disclosures of individuals' PHI.

4. The ***Plan Sponsor*** will make its internal practices, books and records relating to the use and disclosure of individuals' PHI received from the ***Plan*** available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

5. The ***Plan Sponsor*** will, if feasible, return or destroy all individuals' PHI received from the Plan (or a health insurance with respect to the Plan) that the ***Plan Sponsor*** still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the ***Plan Sponsor*** will not retain copies of such PHI after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the ***Plan Sponsor*** will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

6. The ***Plan Sponsor*** will ensure that the required adequate separation, described below, is established and maintained.

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

1. The **Plan**, or a health insurance issuer with respect to the **Plan**, may disclose summary health information to the ***Plan Sponsor*** if the ***Plan Sponsor*** requests the summary health information for the purpose of:

    A. Obtaining premium bids from health plans for providing health insurance coverage under the ***Plan;*** or

    B. Modifying, amending, or terminating the ***Plan.***

2. The ***Plan***, or a ***claims processor*** with respect to the ***Plan***, may disclose enrollment and disenrollment information to the ***Plan Sponsor.***

Required Separation Between the Plan and the Plan Sponsor

1. This section describes the employees or classes of employees or workforce members under the control of

the ***Plan Sponsor*** who may be given access to individuals' PHI received from the ***Plan*** or from the ***claims processor*** servicing the ***Plan***: Insurance Manager

2. This list reflects the employees, classes of employees or other workforce members of the ***Plan Sponsor*** who receive individuals' PHI relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the ***Plan Sponsor*** provides for the ***Plan***. These individuals will have access to individuals' PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the ***Plan Sponsor***) for any use or disclosure of individuals' PHI in violation of, or noncompliance with, the provisions herein.

PRONOUNS

All personal pronouns used in this ***Plan*** shall include either gender unless the context clearly indicates to the contrary.

RECISSION OF COVERAGE

Notwithstanding the provisions for termination of coverage as provided within the section entitled, *Termination of Coverage,* or the retroactive termination of coverage as provided within the section entitled, *General Provisions, Misrepresentation,* should the ***Plan*** determine that a ***covered person's*** coverage hereunder should be terminated, the ***covered person's*** shall be sent a written notice of the effective date of termination of coverage to the last known address of the ***covered person***. Said notice shall be a minimum of thirty (30) calendar days prior to the effective date of termination.

RECOVERY FOR OVERPAYMENT

Whenever payments have been made from the ***Plan*** in excess of the maximum amount of payment necessary, the ***Plan*** will have the right to recover these excess payments. If the company makes any payment that, according to the terms of the ***Plan,*** should not have been made, the ***Plan*** may recover that incorrect payment, whether or not it was made due to the Company's own error, from the person or entity to whom it was made or from any other appropriate party.

SECURITY RULES

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the ***Plan Sponsor*** on behalf of the ***Plan,*** the ***Plan Sponsor*** shall reasonably safeguard the Electronic Protected Health Information as follows:

1. ***Plan Sponsor*** shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that ***Plan Sponsor*** creates, receives, maintains, or transmits on behalf of the ***Plan***;

2. ***Plan Sponsor*** shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

3. ***Plan Sponsor*** shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

4. ***Plan Sponsor*** shall report to the ***Plan*** any ***Security Incidents*** of which it becomes aware as described below:

    A. ***Plan Sponsor*** shall report to the ***Plan*** within a reasonable time after ***Plan Sponsor*** becomes aware, any ***Security Incident*** that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

B. ***Plan Sponsor*** shall report to the ***Plan*** any other ***Security Incident*** on an aggregate basis every quarter, or more frequently upon the ***Plan's*** request.

STATUS CHANGE

If an ***employee*** or ***dependent*** has a status change while covered under this ***Plan*** (i.e. ***dependent*** to ***employee,*** COBRA to Active) and no interruption in coverage has occurred, the ***Plan*** will provide continuance of coverage with respect to any ***preexisting condition*** limitation, deductible(s), ***coinsurance*** and ***maximum benefit.***

TIME EFFECTIVE

The effective time with respect to any dates used in the ***Plan*** shall be 12:00 a.m. (midnight) as may be legally in effect at the address of the ***Plan administrator.***

WORKERS' COMPENSATION NOT AFFECTED

This ***Plan*** is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.

DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in ***bold and italics*** throughout the document:

Administrative Period

The ***administrative period*** is the period of time used by the ***employer*** to assess an ***employee's*** eligibility for coverage under the ***Plan,*** prepare and distribute enrollment materials, and allow time for ***employee*** submission. The ***administrative period*** for new hire ***employees*** shall be two (2) ***calendar months*** starting with the calendar day after the last calendar day of a ***measurement period.*** The ***administrative period*** for ***ongoing employees*** shall be sixty (60) day period of time starting with the calendar day after the last calendar day of a ***measurement period.*** The ***administrative period*** for ***ongoing employees*** shall be two (2) ***calendar months*** of time starting with the calendar day after the last calendar day of a ***measurement period.***

Alternate Recipient

Any child of an ***employee*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan.***

Ambulatory Surgical Facility

A ***facility*** provider with an organized staff of ***physicians*** which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc. or by the ***Plan,*** which:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an ***outpatient*** basis;

2. Provides treatment by or under the supervision of ***physicians*** and nursing services whenever the ***covered person*** is in the ***ambulatory surgical facility;***

3. Does not provide ***inpatient*** accommodations; and

4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a ***physician.***

Approved Clinical Trials

A Phase 1, 2, 3 or 4clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and is one (1) of the following:

1. a federally funded or approved trial;

2. a clinical trial conducted under an FDA investigational new drug application;

3. a drug trial that is exempt from the requirement of an FDA investigational new drug application.

Benefit Year

The twelve-month period of January 1st through December 31st for which all ***Plan*** benefits shall be calculated. Any applicable deductible, out-of-pocket maximum expense limit, or ***maximum benefits*** shall accrue on a ***benefit year*** basis.

Birthing Center

A ***facility*** that meets professionally recognized standards and all of the following tests:

1. It mainly provides an ***outpatient*** setting for childbirth following a normal, uncomplicated ***pregnancy,*** in a home-like atmosphere.

2. It has: (a) at least two (2) delivery rooms; (b) all the medical equipment needed to support the services furnished by the facility; (c) laboratory diagnostic facilities; and (d) emergency equipment, trays, and supplies for use in life threatening situations.

3. It has a medical staff that: (a) is supervised full-time by a ***physician;*** and (b) includes a registered nurse at all times when ***covered persons*** are at the facility.

4. If it is not part of a ***hospital,*** it has written agreement(s) with a local ***hospital(s)*** and a local ambulance company for the immediate transfer of ***covered persons*** who develop complications or who require either pre or post-natal care.

5. It admits only ***covered persons*** who: (a) have undergone an educational program to prepare them for the birth; and (b) have medical records of adequate prenatal care.

6. It schedules ***confinements*** of not more than twenty-four (24) hours for a birth.

7. It maintains medical records for each ***covered person.***

8. It complies with all licensing and other legal requirements that apply.

9. It is not the office or clinic of one or more physicians or a specialized facility other than a birthing center.

Break in Service

A period of at least thirteen (13) consecutive ***weeks*** during which the ***employee*** has no ***hours of service*** for the ***employer.*** A ***break in service*** may also include any period for which the ***employee*** has no ***hours of service*** that is at least four (4) consecutive ***weeks*** in duration and longer than the prior period of employment as determined after application of the procedures applicable to ***special unpaid leaves***.

Calendar Month

One of the twelve (12) months named in the calendar (e.g. January, February, etc.).

Case Management

A program of medical management typically utilized in situations involving extensive and on-going medical treatment, which provides a comprehensive and coordinated delivery of services under the oversight of a medically responsible individual or agency. Such programs may provide benefits not normally covered under ***Plan*** provisions in lieu of ***inpatient hospital*** treatment.

Chemical Dependency

A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) criteria.

Chiropractic Care

Services as provided by a licensed Chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.

Claims Processor

The company contracted by the ***employer*** which is responsible for the processing of claims for benefits under the terms of the ***Plan*** and other ministerial services deemed necessary for the operation of the ***Plan*** as delegated by the ***employer.***

Close Relative

The ***employee's*** spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the ***employee's*** spouse.

Coinsurance

The benefit percentage of ***covered expenses*** payable by the ***Plan*** for benefits that are provided under the ***Plan.*** The ***coinsurance*** is applied to ***covered expenses*** after the deductible(s) have been met, if applicable.

Complications of Pregnancy

A disease, disorder or condition which is diagnosed as distinct from ***pregnancy,*** but is adversely affected by or caused by ***pregnancy.*** Some examples are:

1. Intra-abdominal surgery (but not elective Cesarean Section).

2. Ectopic ***pregnancy.***

3. Toxemia with convulsions (Eclampsia).

4. Pernicious vomiting (hyperemesis gravidarum).

5. Nephrosis.

6. Cardiac Decompensation.

7. Missed Abortion.

8. Miscarriage.

These conditions are not included: false labor; occasional spotting; rest during ***pregnancy*** even if prescribed by a ***physician;*** morning sickness; or like conditions that are not medically termed as ***complications of pregnancy.***

Concurrent Review

A review by the ***Utilization Review Organization*** which occurs during the ***covered person's hospital confinement*** to determine if continued ***inpatient*** care is ***medically necessary.***

Confinement

A continuous stay in a ***hospital, treatment center, extended care facility, hospice,*** or ***birthing center*** due to an ***illness*** or ***injury*** diagnosed by a ***physician.*** Later stays shall be deemed part of the original ***confinement*** unless there was either complete recovery during the interim from the ***illness*** or ***injury*** causing the initial stay, or unless the latter stay results from a cause or causes unrelated to the ***illness*** or ***injury*** causing the initial stay.

Copay

A cost sharing arrangement whereby a ***covered person*** pays a set dollar amount to a provider for a specific service at the time the service is provided.

Cosmetic Surgery, Cosmetic Treatment

Surgery or treatment for the restoration, repair, or reconstruction of body structures directed toward, or resulting in, improvement or preservation of physical appearance rather than to restore the anatomy and/or functions of the body which are lost or impaired due to an ***illness*** or ***injury***.

Covered Expenses

Medically necessary services, supplies or treatments that are recommended or provided by a ***physician, professional provider*** or covered ***facility*** for the treatment of an ***illness*** or ***injury*** and that are not specifically excluded from coverage herein. ***Covered expenses*** shall include specified preventive care services.

Covered Person

A person who is eligible for coverage under this ***Plan,*** or becomes eligible at a later date, and for whom the coverage provided by this ***Plan*** is in effect.

Custodial Care

Care provided primarily for maintenance of the ***covered person*** or which is designed essentially to assist the ***covered person*** in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an ***illness*** or ***injury.*** ***Custodial care*** includes, but is not limited to: help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services shall be considered ***custodial care*** without regard to the provider by whom or by which they are prescribed, recommended or performed.

Room and board and skilled nursing services are not, however, considered ***custodial care*** (1) if provided during ***confinement*** in an institution for which coverage is available under this ***Plan,*** and (2) if combined with other necessary therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the ***covered person's*** medical condition.

Customary and Reasonable Amount

Customary and reasonable amount shall mean ***covered expenses*** which are identified by the ***claims processor,*** taking into consideration the fee(s) which the provider of service most frequently charges the majority of patients for the service or supply; the amount the provider of service accepts from others as payment for the service or supply; the amount the provider of service accepts from others as payment for the service or supply; the cost to the provider of service for providing the service; the prevailing range of fees charged in the same "area" by providers of service of similar training and experience for the service or supply; and the ***Medicare*** reimbursement rates. The ***customary and reasonable amount*** shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross section of providers of service, persons or organizations rendering such treatment, services or supplies for which a specific charge is made.

Dentist

A licensed doctor of dental medicine (D.M.D.) or a licensed doctor of dental surgery (D.D.S.), other than a ***close relative*** of the ***covered person.***

Dependents

For a complete definition of ***dependent,*** refer to *Eligibility, Dependent Eligibility.*

Durable Medical Equipment

Medical equipment which:

1. Can withstand repeated use;

2. Is primarily and customarily used to serve a medical purpose;

3. Is generally not used in the absence of an ***illness*** or ***injury;***

4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered ***durable medical equipment. Durable medical equipment*** includes, but is not limited to: crutches, wheel chairs, ***hospital*** beds, etc.

Effective Date

The date of this ***Plan*** or the date on which the ***covered person's*** coverage commences, whichever occurs later.

Electronic Protected Health Information

The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

Emergency

A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in one or more of the following:

1. Placing the health of the ***covered person*** (or with respect to a pregnant woman, the health of the woman or her unborn fetus) in serious jeopardy, or

2. Serious impairment to bodily functions, or

3. Serious dysfunction of any bodily organ or part, or

With respect to a pregnant woman having contractions:

1. That there is inadequate time to effect a safe transfer to another hospital before delivery, or

2. That transfer may pose a threat to the health or safety of the woman or the unborn child.

Employee, or ***Regular Employee***

For a complete definition of employee, refer to *Eligibility, Employee Eligibility.* Such term shall not include individuals classified by the ***employer*** as independent contractors (including any person who later becomes reclassified as an ***employee*** by the Internal Revenue Service or a court of competent jurisdiction). For purposes of this document, any individual who pays or agrees to pay self-employment tax in lieu of withholding shall be deemed to be an independent contractor, not an ***employee.***

Employer

The ***employer*** is Blackwater Community School.

Enrollment Date

A ***covered person's enrollment date*** is the first day of any applicable service waiting period or the date of hire.

Experimental/Investigational

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

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. If the drug, device, medical treatment or procedure, or the ***covered person*** informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

3. If "reliable evidence" shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

"Reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Extended Care Facility

An institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an ***inpatient*** basis, for persons convalescing from ***illness*** or ***injury,*** professional nursing services, and physical restoration services to assist ***covered persons*** to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a registered nurse.

2. Its services are provided for compensation from its ***covered persons*** and under the full-time supervision of a ***physician*** or Registered Nurse.

3. It provides twenty-four (24) hour a day nursing services.

4. It maintains a complete medical record on each ***covered person.***

5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care, or a place for the care of ***mental and nervous disorders.***

6. It is approved and licensed by ***Medicare.***

This term shall also apply to expenses ***incurred*** in an institution referring to itself as a skilled nursing facility, convalescent nursing facility, or any such other similar designation.

Facility

A healthcare institution which meets all applicable state or local licensure requirements, such as a freestanding dialysis ***facility,*** a lithotriptor center or an outpatient imaging center.

Full-time

A common law ***employee*** who is regularly scheduled to work thirty (30) ***hours of service*** or more per week.

Generic Drug

A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or ***physician*** and must be clearly designated by the pharmacist or ***physician*** as generic.

Hours of Service

Each hour for which the ***employee*** is paid or entitled to payment for performance of services for the ***employer*** AND any hour for which the ***employee*** is paid or entitled to payment by the ***employer*** for a period of time during which no duties are performed due to any of the following:

- Vacation
- Holiday
- Illness or incapacity
- Layoff
- Jury duty
- Military duty or leave of absence

Home Health Aide Services

Those services which may be provided by a person, other than a Registered Nurse, which are ***medically necessary*** for the proper care and treatment of a person.

Home Health Care Agency

An agency or organization which meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.

2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one ***physician*** and at least one Registered Nurse. It must provide for full-time supervision of such services by a ***physician*** or Registered Nurse.

3. It maintains a complete medical record on each ***covered person.***

4. It has a full-time administrator.

5. It qualifies as a reimbursable service under ***Medicare.***

Hospice

An agency that provides counseling and medical services and may provide ***room and board*** to a terminally ill ***covered person*** and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.

2. It provides service twenty-four (24) hours per day, seven (7) days a week.

3. It is under the direct supervision of a ***physician.***

4. It has a Nurse coordinator who is a Registered Nurse.

5. It has a social service coordinator who is licensed.

6. It is an agency that has as its primary purpose the provision of ***hospice*** services.

7. It has a full-time administrator.

8. It maintains written records of services provided to the ***covered person.***

9. It is licensed, if licensing is required.

Hospital

An institution which meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to ***hospitals.***

2. It is engaged primarily in providing medical care and treatment to ***ill*** and ***injured*** persons on an ***inpatient*** basis at the ***covered person's*** expense.

3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an ***illness*** or ***injury;*** and such treatment is provided by or under the supervision of a ***physician*** with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.

4. It qualifies as a ***hospital*** and is accredited by The Joint Commission on the Accreditation of Healthcare Organizations.

5. It must be approved by ***Medicare.***

Under no circumstances will a ***hospital*** be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

Hospital shall include a facility designed exclusively for rehabilitative services where the ***covered person*** received treatment as a result of an ***illness*** or ***injury.***

The term ***hospital,*** when used in conjunction with ***inpatient confinement*** for mental and nervous conditions or ***chemical dependency,*** will be deemed to include an institution which is licensed as a mental ***hospital*** or ***chemical dependency*** rehabilitation and/or detoxification ***facility*** by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

Illness

A bodily disorder, disease, or physical sickness. ***Pregnancy*** of a covered ***employee*** or their covered spouse shall be considered an ***illness.***

Incurred or Incurred Date

With respect to a ***covered expense,*** the date the services, supplies or treatment are provided.

Initial Measurement Period

The twelve (12) ***calendar month*** period beginning on the first day of the ***calendar month*** coinciding with or next following the ***employee's*** date of hire. Notwithstanding the foregoing, the ***employer*** may make adjustments to the ***standard measurement period*** with respect to ***employees*** on payroll periods that are weekly, bi-weekly or semi-monthly in duration.

Injury

A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. ***Injury*** does not include ***illness*** or infection of a cut or wound, or self-inflicted ***injury.***

Inpatient

A ***confinement*** of a ***covered person*** in a ***hospital, hospice,*** or ***extended care facility*** as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for ***room and board.***

Intensive Care

A service which is reserved for critically and seriously ill ***covered persons*** requiring constant audio-visual surveillance which is prescribed by the attending ***physician.***

Intensive Care Unit

A separate, clearly designated service area which is maintained within a ***hospital*** solely for the provision of ***intensive care.*** It must meet the following conditions:

1. Facilities for special nursing care not available in regular rooms and wards of the ***hospital;***

2. Special life saving equipment which is immediately available at all times;

3. At least two beds for the accommodation of the critically ill; and

4. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours per day.

This term does not include care in a surgical recovery room.

Late Enrollee

A ***covered person*** who did not enroll in the ***Plan*** when first eligible or as the result of a Special Enrollment Period.

Layoff

A period of time during which the ***employee,*** at the ***employer's*** request, does not work for the ***employer,*** but which is of a stated or limited duration and after which time the ***employee*** is expected to return to ***full-time, active work.*** Layoffs will otherwise be in accordance with the ***employer's*** standard personnel practices and policies.

Life-threatening Condition

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Leave of Absence

A period of time during which the ***employee*** does not work, but which is of stated duration after which time the ***employee*** is expected to return to active work***.***

Maximum Benefit

Any one of the following, or any combination of the following:

1. The maximum amount paid by this ***Plan*** for any one ***covered person*** for a particular ***covered expense.*** The maximum amount can be for:

   A. The entire time the ***covered person*** is covered under this ***Plan,*** or
   B. A specified period of time, such as a ***benefit year***.

2. The maximum number the ***Plan*** acknowledges as a ***covered expense.*** The maximum number relates to the number of:

   A. Treatments during a specified period of time, or
   B. Days of ***confinement,*** or
   C. Visits by a ***home health care agency.***

Measurement Period

The ***initial measurement period*** or the ***standard measurement period***, as applicable to the Look Back ***measurement period*** method. For the monthly ***measurement period*** method, the ***calendar month.***

Medically Necessary (Medical Necessity)

Service, supply or treatment which, as determined by the ***employer/Plan administrator***, to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the ***covered person's illness*** or ***injury*** and which could not have been omitted without adversely affecting the ***covered person's*** condition or the quality of the care rendered;

2. In accordance with current standards of good medical practice within the organized medical community and is medically proven to be effective treatment of the ***illness*** or ***injury;***

3. The most appropriate supply or level of service that can safely be provided to the ***covered person.*** When applied to an ***inpatient*** admission, this further means that the ***covered person*** requires acute care as a bed patient due to the nature of the services rendered or the ***covered person's illness*** or ***injury,*** and the ***covered person*** cannot receive safe or adequate care as an ***outpatient.***

A service, supply, or treatment will not be considered ***medically necessary*** if:

1. It is provided only as a convenience to the ***covered person*** or provider;

2. It is part of a plan of treatment that is experimental, unproven, or related to research protocol.

The fact that a ***physician*** may prescribe, order, recommend, perform, or approve a service, supply or treatment does not, in and of itself, make the service, supply, or treatment ***medically necessary.*** In making the determination of whether a service or supply was ***medically necessary,*** the ***employer/Plan administrator***, or its designee, may request and rely upon the opinion of a ***physician*** or ***physicians.*** The determination of the ***employer/Plan administrator*** shall be final and binding.

Medicare

The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; and Part C, Miscellaneous provisions regarding both programs; and including any subsequent changes or additions to those programs.

Mental and Nervous Disorder

An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Month

The period that begins on any date following the first day of a ***calendar month*** and that ends on the immediately preceding date in the immediately following ***calendar month*** (for example, from February 2 to March 1 or from December 15 to January 14).

Negotiated Rate

The rate the ***preferred providers*** have contracted to accept as payment in full for ***covered expenses*** of the ***Plan.***

New Employee Stability Period

The twelve (12) ***calendar month*** period that begins on the first calendar day after the end of the ***administrative period,*** as it applies to the Look Back ***measurement period*** method.

Nonparticipating Pharmacy

Any pharmacy, including a ***hospital*** pharmacy, ***physician*** or other organization, licensed to dispense prescription drugs which does not fall within the definition of a ***participating pharmacy.***

Nonpreferred Provider

A ***physician, hospital,*** or other health care provider which does not have an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered.

Nurse

A licensed person holding the degree Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.) or Licensed Vocational Nurse (L.V.N.) who is practicing within the scope of the license.

Ongoing Employee

An ***employee*** who has been employed by the ***employer*** for at least one complete ***standard measurement period,*** as it applies to the Look Back ***measurement period*** method.

Ongoing Employee Stability Period

The twelve (12) ***calendar month*** period that begins on the first day of the ***calendar month*** following the end of the ***administrative period,*** as it applies to the Look Back ***measurement period*** method.

Outpatient

A ***covered person*** shall be considered to be an ***outpatient*** if he is treated at:

1. A ***hospital*** as other than an ***inpatient;***

2. A ***physician's*** office, laboratory or x-ray ***facility;*** or

3. An ***ambulatory surgical facility;*** and

The stay is less than twenty-three (23) consecutive hours.

Partial Confinement

A period of less than twenty-four (24) hours of active treatment in a ***facility*** licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services;

2. Treatment of ***mental and nervous disorders.***

3. Alcoholism treatment;

4. ***Chemical dependency*** treatment;

It may include day, early evening, evening, night care, or a combination of these four.

Participating Pharmacy

Any pharmacy licensed to dispense prescription drugs, which is contracted within the pharmacy organization.

Physician

A person duly licensed to practice medicine, to prescribe and administer drugs, or to perform surgery. This definition includes a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), Dentists, Podiatrists, Chiropractors, Psychologists and Psychiatrists provided that each, who is practicing within the scope of his license, is permitted to perform services covered under this ***Plan*** and that this ***Plan*** does not exclude the services provided by such ***physician.***

Placed For Adoption

The date the ***employee*** assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan

"Plan" refers to the benefits and provisions for payment of same as described herein.

Plan Administrator

The ***Plan administrator*** is responsible for the day-to-day functions and management of the ***Plan.*** The ***Plan administrator*** is the ***employer.***

Plan Documents

The ***Plan's*** governing document and instruments (i.e., the documents under which the group health plan was established and is maintained).

Plan Sponsor

The ***Plan sponsor*** is the ***employer.***

Preferred Provider

A ***physician, hospital*** or other health care ***facility*** who has an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered. ***Preferred providers*** agree to accept the ***negotiated rate*** as payment in full.

Preferred Provider Organization

An organization who selects and contracts with certain ***hospitals, physicians,*** and other health care providers to provide ***covered persons*** services, supplies and treatment at a ***negotiated rate.***

Pregnancy

The physical state which results in childbirth or miscarriage.

Primary Care Physician

General practitioner, family practice, internal medicine, OB/GYN, and pediatrician

Charges from Nurse Practitioners (N.P.) and Physician's Assistants (P.A.) will be considered at the level of the provider they bill under.

Professional Provider

A person or other entity licensed where required and performing services within the scope of such license. The covered ***professional providers*** include, but are not limited to:

Audiologist
Certified Addictions Counselor
Certified Registered Nurse Anesthetist
Certified Registered Nurse Practitioner
Chiropractor
Clinical Laboratory
Clinical Licensed Social Worker (A.C.S.W., L.C.S.W., M.S.W., R.C.S.W., M.A., M.E.D.)
Dietician
Dispensing optician
Midwife
Nurse (R.N., L.P.N., L.V.N.)
Occupational Therapist
Optician
Optometrist
Physical Therapist
Physician
Physician's Assistant
Podiatrist
Psychologist

Respiratory Therapist
Speech Therapist

Qualifying Part-time Employee

For a complete definition of ***qualifying part-time employee***, refer to the section entitled, *Eligibility, Employee Eligibility.*

Reconstructive Surgery

Surgical repair of abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.

Retrospective Review

A review by the ***Utilization Review Organization*** after the ***covered person's*** discharge from ***hospital confinement*** to determine if, and to what extent, ***inpatient*** care was ***medically necessary.***

Room and Board

Room and linen service, dietary service, including meals, ***medically necessary*** special diets and nourishments, and general nursing service. ***Room and board*** does not include personal items.

Seasonal Employee

An ***employee*** hired by the ***employer*** into a position that is expected to average thirty (30) hours or more per ***week***, but typically no longer in duration than six (6) months and begins at the same time of the year each year.

Semiprivate

The daily ***room and board*** charge which a ***facility*** applies to the greatest number of beds in its ***semiprivate*** rooms containing two (2) or more beds.

Security Incidents

The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system. For the purpose of the ***Plan Sponsor's*** requirement to report any ***Security Incidents***, only successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system shall be included.

Special Unpaid Leave of Absence

Any of the following types of unpaid leaves of absence that do not constitute a ***break in service***: (i) Leave protected by the Family and Medical Leave Act, (ii) leave protected by the Uniformed Services Employment and Reemployment Rights Act or (iii) Jury Duty (as reasonably defined by the ***employer***).

Standard Measurement Period

As it applies to the Look Back ***measurement period*** method, the twelve (12) ***month*** period that begins each May 1st and ends April 30th. Notwithstanding the foregoing, the ***employer*** may make adjustments to the ***standard measurement period*** with respect to ***employees*** on payroll periods that are weekly, bi-weekly or semi-monthly in duration.

Total Disability or Totally Disabled

The ***employee*** is prevented from engaging in his regular, customary occupation or from an occupation for which he or she becomes qualified by training or experience, and is performing no work of any kind for compensation or profit; or a ***dependent*** is prevented from engaging in all of the normal activities of a person of like age and sex who is in good health.

Treatment Center

1. An institution which does not qualify as a ***hospital,*** but which does provide a program of effective medical and therapeutic treatment for ***chemical dependency,*** and

2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or

3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:

    A. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
    B. It provides a program of treatment approved by the ***physician.***
    C. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the ***covered person.***
    D. It provides at least the following basic services:
        (1) ***Room and board***
        (2) Evaluation and diagnosis
        (3) Counseling
        (4) Referral and orientation to specialized community resources.

Urgent Care

A claims involving ***urgent care*** is generally a claim for medical care or treatment with respect to which the application of the time periods for making the non-urgent care determinations could seriously jeopardize the life or health of the ***covered person*** or the ability of the ***covered person*** to regain maximum function; or, in the opinion of the ***physician*** with knowledge of the ***covered person's*** medical condition, would subject the ***covered person*** to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Utilization Review

A process of evaluating if services, supplies or treatment are ***medically necessary*** to help ensure cost-effective care.

Utilization Review Organization

The individual or organization designated by the ***employer*** for the process of evaluating whether the service, supply, or treatment is ***medically necessary.***

Week

Any seven (7) consecutive ***calendar***-day period.

Blackwater Community School

Akimel O'otham Pee-Posh Charter School

Employee Benefit Guide

SY 2016- 2017

Medical/ Rx

Dental

Vision

Disability

Life/AD&D

Aflac

Legal Shield

Human Resources (520) 215-5859 Ext. 7910

BALANCE WELLNESS

Intellectual

Spiritual

Emotional

Social

Environmental

Occupational

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Frequently Asked Questions

Who is eligible for benefits?

If you are a full-time employee of Blackwater Community School (working 30 hours or more per week) you are eligible to enroll in the benefits described in this guide.

The following family members are eligible for **medical benefits** through Blackwater Community School:

- Your legally married spouse, including same sex marriages
- Your eligible dependent children who are under age 26;
- Your eligible dependent for whom you hold legal guardianship, under the age of 18;
- Your unmarried children who are at least 19 and are incapable of self-support because of a mental or physical handicap.

The following family members are eligible for **dental and/or vision benefits** through the Blackwater Community School:

- Your legally married spouse;
- Your eligible dependent children who are under age 19;
- Your eligible dependent for whom you hold legal guardianship who are under age 18.
- Your unmarried children who are at least 19 and are incapable of self-support because of a mental or physical handicap.

The following family members are eligible for **life insurance benefits** through the Blackwater Community School:

- Your legally married spouse;
- Your eligible dependent children who are under age 19

You are automatically enrolled in short term disability insurance at no cost to you. This coverage is only available to employees working 30 or more hours per week.

In order to enroll your dependents, you are required to provide appropriate documentation (for example: marriage certificate, birth certificate) at the time of enrollment. Coverage is not available for domestic partner or civil unions. Refer to your Summary Plan Description.

When do my benefits begin?

You must enroll for benefits within 30 days prior to your eligibility date. Otherwise, you may only enroll or make changes during the annual Open Enrollment Period.

For all plans, coverage begins for eligible employees on the first day of the month following 60 days of continuous employment. For exact plan details please refer to your Summary Plan Description.

Frequently Asked Questions

What does annual "Open Enrollment" mean?

Open enrollment provides a window for you to make changes to your plan elections one time per year without having reason to do so. Outside of the Open Enrollment window you are locked in to your benefit elections for the year. Mid-year changes are ONLY allowed if a qualified change, or Life Event, occurs. You must notify Human Resources within 30 days following the date of a qualifying event. Examples of a Life Event are:

- Marriage, legal separation, or divorce
- Birth or adoption of a child
- Change in child's dependent status
- Assignment of legal guardianship
- Death of spouse, child or other qualified dependent
- Spouse's open enrollment
- Change in spouse's employment and/or insurance
- Loss of insurance coverage
- New coverage under another plan

How do I enroll for benefits?

There are three steps to enrollment:

1. Receive benefit package from Human Resources;
2. Submit applications and supporting documentation within 45 days from date of hire or no later than 30 days prior to eligibility date;
3. Understand your options by reading this guide thoroughly.

Can I see any medical provider?

If you are on the EPO plan, you will only have in-network benefits.

If you are on the High Deductible PPO plan, you may use the doctor of your choice and receive benefits. Please note, choosing an in-network provider will result in maximized savings to both you and BWCS. In the event you seek services from an out-of-network provider, you will be subject to higher costs (in the form of deductibles and coinsurance) and may also be balance billed by that provider.

Frequently Asked Questions

How do I pay for my benefits?

You share in the cost of your benefits coverage. Benefit premiums are deducted from 24 of your 26 paychecks.

Blackwater Community School utilizes IRS Section 125 program for premium deductions, allowing you to use pre-tax dollars to pay for your portion of the medical, dental and vision premiums from your paycheck. Insurance premiums are not taxed because they are deducted from your gross wages. Your gross pay, minus these deductions, will be reported on your W-2 statement at the end of the year.

For most individuals, taking advantage of these payroll deductions on a pre-tax basis is beneficial. However, when deductions are taken out of your paycheck on a pre-tax basis, this also reduces the amount that is paid into Social Security, which, in turn, could affect your Social Security benefits. If you are close to retirement, or currently receiving Social Security benefits, you should understand this fact.

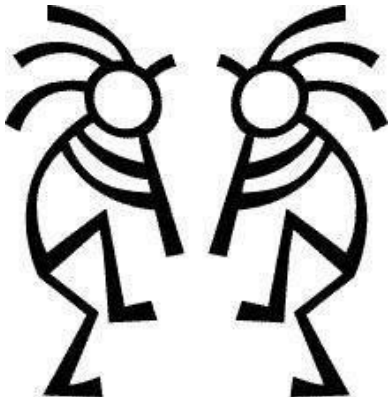
This IRS program mandates that you keep your insurance for the Plan Year.

How Do I Update My Address?

You may update your address by visiting the Human Resource Department and completing a change of address form or through Summit's website, www.summit-inc.net.

Will I receive an I.D. card?

Only employees newly electing or changing medical, dental and/or vision will be receiving a new ID card. In the event you misplace your cards, please contact Human Resources or visit the Summit or Principal websites to order a replacement at www.summit-inc.net or www.principal.com . Please note all ID cards are mailed directly to the employees home.



Medical & Prescription Drugs

The Blackwater Community School offers three choices for medical: EPO, High Deductible PPO Plan and Low Deductible PPO Plan. **You and your family must enroll in the same plan.** Please choose one:

	Option 1: EPO	Option 2: High Deductible PPO	
Services	**In Network Only**	**In Network**	**Out of Network**
Physician Visit **Primary Care Physician*** **Specialist**	$20 Copay then 100% $40 Copay then 100%	80% after deductible	50% after deductible
Calendar Year Deductible **- Individual** **- Family**	$0 $0	$2,000 $4,000	$4,000 $8,000
Coinsurance	100%	80%	50%
Calendar Year Out of Pocket Limit (including deductible) **- Individual** **- Family**	$6,000 $12,000	$6,000 $12,000	$8,000 $16,000
Preventive Care	100%	100%	No benefit
Outpatient Complex Imaging (MRI, PT, CAT Scans)	$50 Copay then 100%	80% after deductible	50% after deductible
Emergency Room	$150 copay per visit then 100%	80% after deductible	50% after deductible
Urgent Care	$50 copay per visit then 100%	80% after deductible	50% after deductible
Inpatient Hospital	$250 copay per admission then 100%	80% after deductible	50% after deductible
Outpatient Hospital	$100 copay per visit then 100%	80% after deductible	50% after deductible
Prescription Drugs **- Generic and Diabetic Medications** **- Preferred Brand Name** **- Non-Preferred Brand Name** **- Specialty** **- Mail Order** **For More Information on your pharmacy benefits, please got to:**	**Magellan RX <u>In-Network Retail Pharmacy Only</u>** $5 copay $25 copay $75 copay $200 copay 1x retail copay for a 90 day supply www.magellanrx.com		

*Primary Care Physician includes General Practitioner, Internist, Ob/Gyn and Pediatrician. You are responsible for fees in excess of the out-of-network allowed amount. The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. This is called balance billing.

Medical & Prescription Drugs (cont'd)

Services	Option 3: Low Deductible PPO	
	In Network	**Out of Network**
Physician Visit **Primary Care Physician*** **Specialist**	70% after deductible	50% after deductible
Calendar Year Deductible **- Individual** **- Family**	$500 $1,000	$1,000 $2,000
Coinsurance	70%	50%
Calendar Year Out of Pocket Limit (including deductible) **- Individual** **- Family**	$6,000 $12,000	$8,000 $16,000
Preventive Care	100%	No benefit
Outpatient Complex Imaging (MRI, PT, CAT Scans)	70% after deductible	50% after deductible
Emergency Room	70% after deductible	20% after deductible
Urgent Care	70% after deductible	50% after deductible
Inpatient Hospital	70% after deductible	50% after deductible
Outpatient Hospital	70% after deductible	50% after deductible
Prescription Drugs **- Generic and Diabetic Medications** **- Preferred Brand Name** **- Non-Preferred Brand Name** **- Specialty** **- Mail Order** **For More Information on your pharmacy benefits, please got to:**	**Magellan RX <u>In-Network Retail Pharmacy Only</u>** $5 copay $25 copay $75 copay $200 copay 1x retail copay for a 90 day supply www.magellanrx.com	

Wellness Plan

Blackwater Community School is committed to investing in the health and well-being of our employees with the belief that healthy employees will be happier, more productive, and have reduced healthcare costs. All employees will have the opportunity to receive **confidential** biometric blood testing, fitness assessment and access to a health coach to review their results. Employees participating will have the ability to participate in a behavior change that will help lead a healthier life based on the coach's recommendation.

These services are provided by an outside wellness vendor in order to **ensure the complete privacy and confidentiality** our employees. All individual results will be confidential between the health coach and the employee. An aggregate data report reflecting the School's overall risk factors will be shared with the plan administrator. Please rest assured this is only an aggregate report and no individual results are available to the School.

We take this matter very seriously. The wellness program is intended to give employees the tools, resources, support and motivation needed to achieve their personal wellness goals. It is voluntary, confidential and free to participate.

We trust you will enjoy participating in this program.

Health Plan Customer Service

Summit P.O. Box 25160 • Scottsdale, AZ 85255 • PH: 888-690-2020 • Fax: 480-505-0406

Online Services

Visit **www.summit-inc.net** to access your personal information 24 hours a day, 7 days a week. Other services available online include:

- **Ordering a replacement ID card;**
- Viewing and printing your Explanation of Benefits;
- Obtaining claim information and details;
- Locating an in-network provider.

You have access to the BlueCross Blue Shield of Arizona provider network. This means you have access to the #1 healthcare network of providers in the state.

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

To find a provider, go to: www.azblue.com/chsnetwork

If you prefer to speak to a customer service representative for Summit you may call toll-free:
1-888-690-2020 (Group Number 430)

Hours are Monday through Friday from 8 a.m. to 5 p.m., excluding holidays.

Health Plan Customer Service

Who is Eligible?

If you are covered by the Blackwater Community School medical plan, you will automatically be enrolled in the Hines program. Hines has a specialized staff of nurses who are available to help with any complex medical issues you or your covered dependents may be facing.

Examples of health conditions where Hines can help you and your family:

Medical Case Management

Cancer

Heart Attack

Specialty Medications – Any

Serious Medical Condition

All services provided by Hines &Associates are paid-for 100% by Blackwater Community School, and are 100% confidential.

Hines®

Our Experience Works for You

Important!

Before receiving any inpatient or outpatient treatment, surgery, extensive testing such as MRI, PET or CAT scan, chemotherapy, radiation therapy or specialty medication you or your doctor must call Hines at:

1-800-944-9401

It is your responsibility to read your Summary Plan Description which outlines all services when Hines must be notified. If you do not notify Hines when necessary, your benefits will be reduced.

Dental Plan

Blackwater Community School's plan only pays benefits when services rendered are from a provider that is in-network. To find a provider, please go to www.principal.com and search for a dental provider or call 1-800-247-4695. **Please note, this plan does not have an out-of-network benefit.**

Services	In Network
Preventive Services Exams Routing Cleanings (2 per calendar year) X-rays	100% no deductible
Calendar Year Deductible	Individual: $50, Family: $150 Applies to basic and major services only
Basic Services Fillings Simple Extractions Endodontics (root canal) Periodontics (gum disease) Oral Surgery	100% after deductible
Major Services Crowns Dentures Bridges	80% after deductible
Annual Maximum	$2,500
Orthodontia (Dependent Children up to age 19 only)	50% no deductible Lifetime Maximum of $1,000 per child

For questions on your dental plan, including claims, provider lookup and benefit verification, please call 1-800-247-4695, option 3.

You may also visit www.principal.com and select "Login - personal" in the upper right corner.

Your group number: **1056825**

Principal® Financial Group

Vision Plan

The Blackwater Community School offers vision insurance through Principal Financial. This chart provides you an overview of your vision benefits. For more information on out-of-network benefits, please see your benefit summary or create an account using the below instructions.

Services	In Network
Vision Exam Copay	$10 copay
Benefit for Frames **Plan Allowance**	No copay; $150 benefit
Lenses	$10 copay Covered at 100% Limitations may apply to specialty lenses and vendors
Contact Lenses **Elective** **Medically Necessary**	$150 benefit per benefit year $10 copay / $500 benefit (authorization required)
Lens Tint **Ultra-Violet Protection** **Scratch Coat Options** **Other Lens Options (such as transition lenses)**	20-25% discount for Lens options
Frequency of Benefits **Standard Eye Exam** **Eyeglass Frames** **Eyeglass Lenses** **Contact Lenses**	 1 (one) eye exam every 12 months 1 (one) pair of frames every 24 months 1 (one) pair of lenses every 12 months 1 (one) pair of contact lenses every 12 months
LASIK Benefit	An average of 15% off the regular price or 5% off the promotional offer

For questions on your vision plan, including claims, provider lookup and benefit verification, please call 1-800-877-7195.

You may also register for a VSP.COM account with your social security number as your member ID.

Your VSP Network: **VSP Choice Network**
Your group number: **1056825**

Principal® Financial Group

VSP® Vision care for life

Life Insurance and AD&D Plan

When Does My Life Insurance Coverage Begin?

Coverage begins on the first day of the month following 60 days continuous employment, provided you are actively at work when coverage begins. Benefits paid will not exceed the maximum benefit. Spouse and child(ren) life benefits are all guaranteed, provided the insured is not confined in a hospital on the day coverage begins.

	Basic Life Insurance and AD&D	Optional Life and AD&D
Employee Guaranteed Amount Maximum Benefit	1x salary $100,000 $100,000 (Employer paid)	Increments of $10,000 $100,000 $500,000
Spouse Guaranteed Amount Maximum Benefit	$20,000 $20,000 $20,000	Increments of $5,000 $10,000 $150,000
Child Guaranteed Amount Maximum Benefit	$5,000 $5,000 $5,000	$2,000, $4,000, or $10,000 benefit $10,000 $10,000

Designating Your Beneficiary

In the event of your death, benefit payments are made based on your most recent signed beneficiary designation. Therefore, it is important to keep this updated. You must provide a signed beneficiary designation form upon enrollment. You may change your beneficiary any time throughout the year or at Open Enrollment. Please send your completed beneficiary form to Human Resources.

Short & Long Disability Plan

Short Term Disability

Benefits begin on the first day of the month after 60 days of continuous full-time employment. This benefit is paid on your behalf by Blackwater Community School.

	Short Term Disability
Benefits Begin	On the 31st day of Disability
Benefits Payable	On the 31st day of Disability up to 26 weeks
Percentage of Income Replaced	60%
Maximum Weekly Benefit	$500 per week

In the event you are disabled and need to report a claim, call Principal on their toll-free number to speak with a customer intake representative who will walk you through the process. They will take all of your information over the phone. First notify Human Resources and then call 1-800-262-3283.

Long Term Disability

Provided by Arizona State Retirement (ASRS)

If you participate in ASRS, you are auto enrolled for the long term disability plan. This benefit is partially paid for by the employee with matching employer contributions. If you need additional information, please visit their website at www.azasrs.gov .

Employee Assistance Plan (EAP)

Blackwater Community School cares about your well-being. To assist you, they have contracted with Magellan Healthcare to provide several services to help balance your work-life. The EAP is a confidential counseling and referral service that can help you and your family successfully deal with life's challenges. EAP services are available to you at no cost, as your employer has prepaid these services.

Services	In Network
Face to Face Counseling	Up to 3 counseling sessions available per incident per year. The EAP can help with things like stress, anxiety, depression, relationship problems, job or work stress, parenting, alcohol and drugs, legal issues and financial concerns.
Financial Counseling	Sixty (60) minute consultation with a financial counselor on issues such as budgeting, debt consolidation, loans, mortgage assistance, retirement, IRS matters, etc. Magellan counselors will provide referrals when needed. (Limit one 60-minute consultation per issue per year)
Legal and Mediation Services	Sixty (60) minute consultation with an attorney on any type of legal matter. The 60 minute offering is available for one consultation per topic each year. For services beyond the 60 minutes, members receive a preferred discount rate of 25% off the hourly fee. (Limit one 60-minute consultation per issue per year)
Online Services	Interactive website offers a variety of health and well-being information, including: Healthy Living Topics, Self-Assessments for Behavioral Health, Life Management, Workplace, Families & Parenting, Pre-recorded webinars, Life Mart Discount Center, Podcosts, etc.

EAP services provided by Magellan Healthcare are available 24 hours a day, 7 days a week from anywhere in the United States.

Phone: 1-800-356-7089
Website: www.magellanhealth.com/member

Additional Employee Paid Options

As a Blackwater Community School employee, Verizon Wireless offers you discounts up to 15% on eligible wireless products and services.

Aflac products pay you money when you need it the most! Call our Aflac representative to find out about the plans available to you at a lower group rate.

LegalShield is prepaid legal program that offers legal advice, document review, letters and phone calls on your behalf, etc. For more information on the plans available, please call our LegalShield representative.

Federal Notices

The Department of Labor (DOL), the Department of Health and Human Services (HHS) and the Internal Revenue Service (IRS) require certain information related to health benefit plans be issued to employees in writing. These notices explain your rights and obligations in relation to the health plan provided by your employer. Please note this is not a legal document and should not be construed as legal advice.

The following is a summary of notices included in this packet:

- Consolidated Omnibus Budget Reconciliation Act - COBRA
- Family Medical Leave Act - FMLA
- Genetic Information Nondiscrimination Act - GINA
- HIPAA Privacy Notice
- HIPAA Special Enrollment Rights
- Medicaid and Child Health Insurance - CHIP
- Medicare Part D Notice
- Qualified Medical Child Support Order - QMCSO
- Uniformed Services Employment and Reemployment Rights Act - USERRA
- Newborn and Mother's' Health Protection Act - NMHPA
- Women's Health and Cancer Rights Act - WHCRA

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

The Consolidated Omnibus Budget Reconciliation Act gives workers and their families who lose their health benefits the right to choose to continue group health benefits for limited periods of time under certain circumstances, such as, voluntary or involuntary job loss, reduction in the hours worked, death, divorce, and other events. Qualified individuals may be required to pay the entire cost for coverage up to 102% of the cost for the Plan.

FAMILY MEDICAL LEAVE ACT (FMLA)

The Family Medical Leave Act entitles eligible employees of covered employers to take unpaid, job-protected leave due to a serious health condition for the employee or immediate family. To be eligible, the employee must have worked at least 1,250 hours during the prior 12 consecutive months. For additional details, visit the Department of Labor FMLA page. Notify your employer when you have a qualifying event, such as, birth or adoption of a child, a serious health condition, need to care for a spouse, child or parent with a serious medical condition, or for reservist or National Guard provisions related to you or an immediate family member leaving for military duty or being injured in active duty.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

The Genetic Information Nondiscrimination Act is designed to prohibit the use of genetic information in health insurance and employment. The Act prohibits group health plans and health insurers from denying coverage to a healthy individual or charging that person higher premiums based solely on a genetic predisposition to developing a disease in the future. The legislation also bars employers from using individual's genetic information when making hiring, firing, job placement or promotion decision.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)-PRIVACY NOTICE

One of the many components of the Health Insurance Portability and Accountability Act (HIPAA) is privacy of an individual's Protected Health Information (PHI). The HIPAA privacy rule requires a health plan to remind employees no less frequently than once every three years of the availability of its notice of privacy practices as well as how to obtain a copy. Remember, it is the Privacy Practices adopted by your employer that must be distributed to all employees. You can accessadditional information about the required reminder notice to employees at the Office for Civil Rights website, *http://www.hhs.gov/ocr/hipaa* and clicking on FAQs, Notice of Privacy Practices.

HIPAA SPECIAL ENROLLMENT RIGHTS

If you and/or your dependents lose other group health coverage, or you acquire a dependent, such as, marriage, birth or adoption, you have special enrollment rights in the employer's group health plan allowing you to enroll dependents during the year other than open enrollment. **You must submit a completed application for enrollment in the health plan to the employer within30 days of the loss of other coverage or dependent acquisition in order to enroll the dependents. Failure to enroll within 30 days results in waiting until the next open enrollment.**

Federal Notices

MEDICAID AND CHILD HEALTH INSURANCE (CHIP)

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have a premium assistance program that can help pay for coverage. If you or your dependent(s) are not currently enrolled in Medicaid or CHIP, and you think your dependent(s) might be eligible, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or *www.insurekidsnow.gov* to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer sponsored plan. Once it is determined that you or your dependent(s) are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit your dependent(s) to enroll in the Plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. **You have 60 days to request coverage after it is determined you are eligible for premium assistance.**

Arizona CHIP website: www.azahcccs.gov/applicants

Arizona CHIP telephone: (Outside of Maricopa County): 1-877-764-5437 (Maricopa County): 602-417-5437

MEDICARE PART D NOTICE

Your employer will issue a notice prior to October 15. The notice explains the options you have under Medicare prescription drug coverage. It also has information about your current prescription drug coverage with your employer. It will guide you where to find more information to help you make decisions about your prescription drug plan. If you or any of your eligible dependents are eligible for Medicare, please read the notice. If you are not, you can disregard the notice.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A qualified medical child support order is issued under state law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits. An "alternate recipient" is any child of an employee or spouse (including a child adopted by or placed for adoption) who is recognized under a medical child support order as having a right to enrollment under a group health plan. Upon receipt, the employer is required to determine within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each qualified order. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer. Like most other prescribed timelines for enrolling under this provision, you must provide a completed application for enrollment for the alternate recipient within 30 days of the court order.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT NOTICE (USERRA)

Your right to continued participation in the Plan during leave of absences for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act. Accordingly, if you are absent from work due to a period of active duty in the military for less than 30 days, your Plan participation will not be interrupted. If the absences more than 30 days, but not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 30 days or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA only under the medical coverage for the 24-month period that begins on the first day of your leave of absence. You must pay the cost for COBRA with after-tax funds, subject to the rules that are set out in the Plan.

NEWBORN AND MOTHER'S HEALTH PROTECTION ACT (NMHPA)

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

The Women's Health and Cancer Rights Act (WHCRA) provides protection for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must also provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient. Required coverage includes all stages of reconstruction of the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Contact Information

The Mahoney Group	623-215-1321 Christie Thomas
Summit	1-888-690-2020 Michelle McGowan
Principal Financial Group	1-800-247-4695
Hines www.hinesassoc.com	1-800-944-9401
Aflac	602-220-0570 Hal Elliot
LegalShield	602-369-5890 Tanisha Morgan

Human Resources
(520) 215-5859 X 7910

Blackwater Community Schools Employee Benefit Plan (EPO Plan): Blackwater Community Schools

Coverage Period: 07/1/16- 06/30/17

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual & Family | Plan Type: PPO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or **plan** document by calling the plan at 520-215-7910. (Note: the Uniform Glossary can be accessed at: www.dol.gov/ebsa/healthreform).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Per calendar year - **PPO** - $0 Per Person - **Non-PPO** - $2,000 Per Person; **Deductible** doesn't apply to **PPO** preventive care; prescription drugs	You must pay all costs up to the **deductible** amount before this **plan** begins to pay for covered services you use. Check your plan document to see when the **deductible** starts over (usually, but not always, January 1st). See chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this **plan** covers.
Is there an out–of–pocket limit on my expenses?	Yes – for **PPO Providers and RX** only - $6,000 Per Person/$12,000 Per Family	The **out-of-pocket limit** is the most you could pay for covered services during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	**Premiums, balanced billed charges** and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the **plan** will pay for specific covered services, such as office visits.
Does this plan use a network of participating providers?	Yes. The **PPO** is BCBSAZ. See www.azblue.com/CHSnetwork or call Summit at 1-888-690-2020 for a list of **PPO providers**	If you use a **PPO provider** doctor or other health care provider, this **plan** will pay some or all of the costs of covered services. Be aware, your **PPO provider** doctor or hospital may use a **Non-PPO provider** for some services. Plans use the term **in-network, preferred or participating providers** in their network. See the chart starting on page 2 for how this **plan** pays different providers.
Do I need a referral to see a specialist?	No	You can see the specialist you choose without permission from the **plan.**
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or **plan** document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the **plan** pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This **plan** may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	**Primary care** visit to treat an injury or illness	$20 **copay**	50% **coinsurance**	**Primary care physician** includes general practitioner, internist, ob/gyn, pediatrician
	Specialist visit	$40 **copay**	50% **coinsurance**	Limited to 20 visits per calendar year for chiropractic and outpatient therapy
	Other practitioner office visit	$20 **copay**	50% **coinsurance**	
	Preventive care/screening/immunization	0% **coinsurance**	Not Covered	Based on age and gender related tests.
If you have a test	Diagnostic test (x-ray, blood work)	0% **coinsurance**	50% **coinsurance**	
	Imaging (CT/PET scans, MRIs)	$50 **copay**	50% **coinsurance**	

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com	Contraceptives and Mandated OTC Drugs	Retail - $0 **copay**	Not Covered	Limited to a 30 day supply
	Generic drugs	Retail - $5 **copay** Mail - $5 **copay**	Not Covered	Limited to 30 day supply – Retail 90 day supply - Mail
	Formulary Brand Name drugs	Retail - $25 **copay** Mail - $25 **copay**	Not Covered	Limited to 30 day supply – Retail 90 day supply - Mail
	Non-Formulary Brand Name drugs	Retail - $75 **copay** Mail - $75 **copay**	Not Covered	Limited to 30 day supply – Retail 90 day supply - Mail
	Specialty Drugs	Retail - $200 **copay** Mail - $200 **copay**	Not Covered	Requires precertification
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 **copay**	50% **coinsurance**	Specified outpatient procedures require precertification. $300 penalty for noncompliance.
	Physician/surgeon fees	0% **coinsurance**	50% **coinsurance**	
If you need immediate medical attention	**Emergency room services**	$150 **copay**	$150 **copay**	**Deductible** waived for **Non-PPO**
	Emergency medical transportation	0% **coinsurance**	50% **coinsurance**	
	Urgent care	$50 **copay**	50% **coinsurance**	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 **copay**	50% **coinsurance**	Precertification required. $300 penalty for noncompliance.
	Physician/surgeon fee	0% **coinsurance**	50% **coinsurance**	

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 **copay** for first 10 visits; then 0% **coinsurance**	50% **coinsurance**	Precertification required. $300 penalty for noncompliance.
	Mental/Behavioral health inpatient services	$250 **copay**	50% **coinsurance**	
	Substance abuse disorder outpatient services	$10 **copay** for first 10 visits; then 0% **coinsurance**	50% **coinsurance**	
	Substance abuse disorder inpatient services	$250 **copay**	50% **coinsurance**	
If you are pregnant	Prenatal and postnatal care **Physician**	0% **coinsurance**	50% **coinsurance**	Routine prenatal care is payable as preventive care.
	Delivery and all inpatient services	0% **coinsurance**	50% **coinsurance**	
If you need help recovering or have other special health needs	**Home health care**	0% **coinsurance**	50% **coinsurance**	
	Rehabilitation services	0% **coinsurance**	50% **coinsurance**	Limited to 20 visits per calendar year for physical and occupational therapy and 20 visits per calendar year for speech therapy
	Habilitation services	0% **coinsurance**	50% **coinsurance**	
	Skilled nursing care	0% **coinsurance**	50% **coinsurance**	
	Durable medical equipment	0% **coinsurance**	50% **coinsurance**	
	Hospice service	0% **coinsurance**	50% **coinsurance**	
If your child needs dental or eye care	Eye exam	0% **coinsurance**	Not Covered	Covered under preventive care
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery or complications as a result of such services
- Dental Care
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the United States.
- Private Duty Nursing
- Refractive Eye Surgery
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic Care
- Hearing Aids

Your Rights to Continue Coverage:

If you lose coverage under the **plan**, then depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the **plan**. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the **plan** at 502-215-7910. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 X 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your **plan**, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Blackwater Community Schools: (502) 215-79810 or the Department of Labor, Employee Benefit Security Administration at 1-866-444-EBSA or www.dol.ebsa/healthreform.

Does This Plan Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does This Coverage Meet The Minimum Value Standard?

The Affordable Care Act established a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this **plan** might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this **plan**. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,515
- **Patient pays** $25

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$25
Coinsurance	$0
Limits or exclusions	$0
Total	**$25**

Note: Assumes **PPO Providers**
Assumes all charges are for the mother except routine nursery, vaccines and other preventive
Assumes 5 generic prescriptions

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,220
- **Patient pays** $180

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$180
Coinsurance	$0
Limits or exclusions	$0
Total	**$180**

Note: Assumes **PPO Providers**
Assumes 12 generic prescriptions
Assumes 4 physician office visits

Questions and Answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Blackwater Community Schools Employee Benefit Plan (PPO Plan): Blackwater Community Schools

Coverage Period: 07/1/16- 06/30/17

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual & Family | Plan Type: PPO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or **plan** document by calling the plan at 520-215-7910. (Note: the Uniform Glossary can be accessed at: www.dol.gov/ebsa/healthreform).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Per calendar year - **PPO** - $2,000 Per Person/$4,000 Per Family - **Non-PPO** - $4,000 Per Person/$8,000 Per Family; **Deductible** doesn't apply to **PPO** preventive care; prescription drugs	You must pay all costs up to the **deductible** amount before this **plan** begins to pay for covered services you use. Check your plan document to see when the **deductible** starts over (usually, but not always, January 1st). See chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this **plan** covers.
Is there an out–of–pocket limit on my expenses?	Yes - **PPO and RX** - $6,000 Per Person/ $12,000 Per Family; **Non-PPO** - $8,000 Per Person/$16,000 Per Family	The **out-of-pocket limit** is the most you could pay for covered services during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	**Premiums, balanced billed charges** and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the **plan** will pay for specific covered services, such as office visits.
Does this plan use a network of participating providers?	Yes. The **PPO** is BCBSAZ. See www.azblue.com/CHSnetwork or call Summit at 1-888-690-2020 for a list of **PPO providers**	If you use a **PPO provider** doctor or other health care provider, this **plan** will pay some or all of the costs of covered services. Be aware, your **PPO provider** doctor or hospital may use a **Non-PPO provider** for some services. Plans use the term **in-network, preferred or participating providers** in their network. See the chart starting on page 2 for how this **plan** pays different providers.
Do I need a referral to see a specialist?	No	You can see the specialist you choose without permission from the **plan.**
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or **plan** document for additional information about **excluded services**.

Questions: Call 1- 520-215-5859 x- 7910
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can call 1-520-215-5859 x- 7910 to request a copy.

OMB Control Numbers 1545-2229
1210-0147, and 0938-1146
Corrected on May 11, 2012

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the **plan** pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This **plan** may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	**Primary care** visit to treat an injury or illness	20% **coinsurance**	50% **coinsurance**	Limited to 20 visits per calendar year for chiropractic and outpatient therapy
	Specialist visit	20% **coinsurance**	50% **coinsurance**	
	Other practitioner office visit	20% **coinsurance**	50% **coinsurance**	
	Preventive care/screening/immunization	0% **coinsurance**	Not Covered	**PPO deductible** waived.
If you have a test	Diagnostic test (x-ray, blood work)	20% **coinsurance**	50% **coinsurance**	
	Imaging (CT/PET scans, MRIs)	20% **coinsurance**	50% **coinsurance**	

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com	Contraceptives and Mandated OTC Drugs	Retail - $0 **copay**	Not Covered	Limited to a 30 day supply
	Generic drugs	Retail - $5 **copay** Mail - $5 **copay**	Not Covered	Limited to 30 day supply – Retail 90 day supply - Mail
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	Physician/surgeon fee	20% **coinsurance**	50% **coinsurance**	

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% **coinsurance**	50% **coinsurance**	Precertification required. $300 penalty for noncompliance.
	Mental/Behavioral health inpatient services	20% **coinsurance**	50% **coinsurance**	
	Substance abuse disorder outpatient services	20% **coinsurance**	50% **coinsurance**	
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	Delivery and all inpatient services	20% **coinsurance**	50% **coinsurance**	
If you need help recovering or have other special health needs	**Home health care**	20% **coinsurance**	50% **coinsurance**	
	Rehabilitation services	20% **coinsurance**	50% **coinsurance**	Limited to 20 visits per calendar year for physical and occupational therapy and 20 visits per calendar year for speech therapy
	Habilitation services	20% **coinsurance**	50% **coinsurance**	
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	Durable medical equipment	20% **coinsurance**	50% **coinsurance**	
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If your child needs dental or eye care	Eye exam	0% **coinsurance**	Not Covered	Covered under preventive care with **deductible waived.**
	Glasses	Not Covered	Not Covered	
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Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

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- Dental Care
- Infertility Treatment
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- Chiropractic Care
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This is not a cost estimator.

Don't use these examples to estimate your actual costs under this **plan**. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,455
- **Patient pays** $3,085

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$25
Coinsurance	$1,060
Limits or exclusions	$0
Total	**$3,085**

Note: Assumes **PPO Providers**
Assumes all charges are for the mother except routine nursery, vaccines and other preventive
Assumes 5 generic prescriptions

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,260
- **Patient pays** $2,140

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Copays	$60
Coinsurance	$80
Limits or exclusions	$0
Total	**$2,140**

Note: Assumes **PPO Providers**
Assumes 12 generic prescriptions
Assumes 4 physician office visits

Questions and Answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

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Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Blackwater Community Schools Employee Benefit Plan (PPO Plan): Blackwater Community Schools

Coverage Period: 07/1/16- 06/30/17

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual & Family | Plan Type: PPO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or **plan** document by calling the plan at 520-215-7910. (Note: the Uniform Glossary can be accessed at: www.dol.gov/ebsa/healthreform).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Per calendar year - **PPO** - $500 Per Person/$1,000 Per Family - **Non-PPO** - $1,000 Per Person/$2,000 Per Family; **Deductible** doesn't apply to **PPO** preventive care; prescription drugs	You must pay all costs up to the **deductible** amount before this **plan** begins to pay for covered services you use. Check your plan document to see when the **deductible** starts over (usually, but not always, January 1st). See chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this **plan** covers.
Is there an out–of–pocket limit on my expenses?	Yes - **PPO & RX** - $6,000 Per Person/ $12,000 Per Family; **Non-PPO** - $8,000 Per Person/$16,000 Per Family	The **out-of-pocket limit** is the most you could pay for covered services during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	**Premiums, balanced billed charges** and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the **plan** will pay for specific covered services, such as office visits.
Does this plan use a network of participating providers?	Yes. The **PPO** is BCBSAZ. See www.azblue.com/CHSnetwork or call Summit at 1-888-690-2020 for a list of **PPO providers**	If you use a **PPO provider** doctor or other health care provider, this **plan** will pay some or all of the costs of covered services. Be aware, your **PPO provider** doctor or hospital may use a **Non-PPO provider** for some services. Plans use the term **in-network, preferred or participating providers** in their network. See the chart starting on page 2 for how this **plan** pays different providers.
Do I need a referral to see a specialist?	No	You can see the specialist you choose without permission from the **plan.**
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or **plan** document for additional information about **excluded services**.

Questions: Call 1- 520-215-5859 x- 7910
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can call 1-520-215-5859 x- 7910 to request a copy.

OMB Control Numbers 1545-2229
1210-0147, and 0938-1146
Corrected on May 11, 2012

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the **plan** pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This **plan** may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	**Primary care** visit to treat an injury or illness	30% **coinsurance**	50% **coinsurance**	Limited to 20 visits per calendar year for chiropractic and outpatient therapy
	Specialist visit	30% **coinsurance**	50% **coinsurance**	
	Other practitioner office visit	30% **coinsurance**	50% **coinsurance**	
	Preventive care/screening/immunization	0% **coinsurance**	Not Covered	**PPO deductible** waived.
If you have a test	Diagnostic test (x-ray, blood work)	30% **coinsurance**	50% **coinsurance**	
	Imaging (CT/PET scans, MRIs)	30% **coinsurance**	50% **coinsurance**	

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com	Contraceptives and Mandated OTC Drugs	Retail - $0 **copay**	Not Covered	Limited to a 30 day supply
	Generic drugs	Retail - $5 **copay** Mail - $5 **copay**	Not Covered	Limited to 30 day supply – Retail 90 day supply - Mail
	Formulary Brand Name drugs	Retail - $25 **copay** Mail - $25 **copay**	Not Covered	Limited to 30 day supply – Retail 90 day supply - Mail
	Non-Formulary Brand Name drugs	Retail - $75 **copay** Mail - $75 **copay**	Not Covered	Limited to 30 day supply – Retail 90 day supply - Mail
	Specialty Drugs	Retail - $200 **copay** Mail - $200 **copay**	Not Covered	Requires precertification
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% **coinsurance**	50% **coinsurance**	Specified outpatient procedures require precertification. $300 penalty for noncompliance.
	Physician/surgeon fees	30% **coinsurance**	50% **coinsurance**	
If you need immediate medical attention	**Emergency room services**	30% **coinsurance**	20% **coinsurance**	**PPO deductible** applies to **Non-PPO** treatment
	Emergency medical transportation	30% **coinsurance**	20% **coinsurance**	
	Urgent care	30% **coinsurance**	50% **coinsurance**	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% **coinsurance**	50% **coinsurance**	Precertification required. $300 penalty for noncompliance.
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Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% **coinsurance**	50% **coinsurance**	Precertification required. $300 penalty for noncompliance.
	Mental/Behavioral health inpatient services	30% **coinsurance**	50% **coinsurance**	
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If you are pregnant	Prenatal and postnatal care **Physician**	30% **coinsurance**	50% **coinsurance**	Routine prenatal care is payable as preventive care.
	Delivery and all inpatient services	30% **coinsurance**	50% **coinsurance**	
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Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

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Copays	$10
Coinsurance	$2,030
Limits or exclusions	$150
Total	**$2,690**

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(routine maintenance of a well-controlled condition)

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Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$190
Coinsurance	$660
Limits or exclusions	$80
Total	**$1,430**

Note: Assumes **PPO Providers**
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Assumes 4 physician office visits

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BLACKWATER COMMUNITY SCHOOL WRAP PLAN

Established as of **October 1, 2015**

BLACKWATER COMMUNITY SCHOOL WRAP PLAN

TABLE OF CONTENTS

ARTICLE 1: VARIABLE PROVISIONS/DEFINITIONS

Section 1.01 PLAN

This Plan is intended to qualify as a welfare benefit plan of the Company under ERISA.

Section 1.02 PLAN SPONSOR

Name of adopting employer (Plan Sponsor): **Blackwater Community School**.

"Company" means the Plan Sponsor and any other entity that adopts the Plan with the consent of the Plan Sponsor.

Section 1.03 GENERAL PLAN INFORMATION

(a) Plan name: **Blackwater Community School Wrap Plan**.

(b) Plan number: **501**

(c) Effective Date: **October 1, 2015** .

(d) "Plan Year" means each 12-consecutive month period ending on: **June 30** .

Section 1.04 SUBSIDIARY CONTRACTS

"Subsidiary Contract" means any agreement, writing, contract, plan or arrangement between the Company and the welfare benefit provider(s) specified in the Subsidiary Contracts Addendum, plus any successor providers.

In addition, any statements of coverage provided by the Plan Administrator setting forth a description of the scope of coverage under the Plan as well as the options, terms, conditions and limitations related thereto are herein incorporated as part of the Subsidiary Contracts.

Section 1.05 ELIGIBILITY

(a) Eligibility for benefits under the Subsidiary Contracts shall be determined by the Subsidiary Contracts. Eligibility information relating to medical coverage offered under this Plan is further specified in the ACA Eligibility Addendum.

(b) "Participant" means an employee of the Company that participates in one or more Subsidiary Contracts.

Section 1.06 PLAN OPERATIONS

The Plan Administrator shall be the Plan Sponsor. The Plan Administrator shall also be the named fiduciary within the meaning of ERISA section 402.

Section 1.07 INDEMNIFICATION

The Company shall indemnify and hold harmless any person serving as the Plan Administrator (and its delegate) from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under this Plan or ERISA.

ARTICLE 2: BENEFITS

Section 2.01 INCORPORATION BY REFERENCE

The actual terms and conditions of the Subsidiary Contracts offered under this Plan are contained in separate, written documents governing each respective benefit, and shall govern in the event of a conflict between the individual plan document and this Plan. To that end, each such separate Subsidiary Contract, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein.

ARTICLE 3: PLAN ADMINISTRATION

Section 3.01 PLAN ADMINISTRATOR

(a) Designation. The Plan Administrator shall be specified in Article 1. In the absence of a designation in Article 1, the Plan Sponsor shall be the Plan Administrator. If a Committee is designated as the Plan Administrator, the Committee shall consist of one or more individuals who may be employees appointed by the Plan Sponsor and the Committee shall elect a chairman and may adopt such rules and procedures as it deems desirable. The Committee may also take action with or without formal meetings and may authorize one or more individuals, who may or may not be members of the Committee, to execute documents in its behalf.

(b) Authority and Responsibility of the Plan Administrator. The Plan Administrator shall be the Plan "administrator" as such term is defined in section 3(16) of ERISA, and as such shall have total and complete discretionary power and authority:

(i) to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation or application of the Plan by the Plan Administrator shall be final, conclusive and binding;

(ii) to determine the amount, form or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for benefits in accordance with Article 5;

(iii) to determine the amount and manner of any allocations hereunder;

(iv) to maintain and preserve records relating to the Plan;

(v) to prepare and furnish all information and notices required under applicable law or the provisions of this Plan;

(vi) to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all reports and other information required under law to be so filed or published;

(vii) to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;

(viii) to determine all questions of the eligibility of employees and of the status of rights of Participants under the Plan;

(ix) to determine the validity of any judicial order;

(x) to retain records on elections and waivers by Participants;

(xi) to supply such information to any person as may be required;

(xii) to perform such other functions and duties as are set forth in the Plan that are not specifically given to any other fiduciary or other person.

(c) Procedures. The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information

furnished to it. The Plan Administrator's decisions shall be binding and conclusive as to all parties.

(d) Allocation of Duties and Responsibilities. The Plan Administrator may designate other persons to carry out any of his duties and responsibilities under the Plan.

(e) Compensation. The Plan Administrator shall serve without compensation for its services.

(f) Expenses. All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder shall be paid or reimbursed by the Company.

(g) Allocation of Fiduciary Duties. A Plan fiduciary shall have only those specific powers, duties, responsibilities and obligations as are explicitly given him under the Plan. It is intended that each fiduciary shall not be responsible for any act or failure to act of another fiduciary. A fiduciary may serve in more than one fiduciary capacity with respect to the Plan.

Section 3.02 MEDICAL CHILD SUPPORT ORDERS

In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA section 609(a)(2)(B)), the Plan Administrator shall notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of ERISA section 609(a)(2)(A)). Within a reasonable period the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and alternate recipient of such determination.

Section 3.03 FMLA/USERRA

To the extent the Plan is subject to the Family Medical Leave Act (FMLA), the Plan Administrator shall permit a Participant taking unpaid leave under the FMLA to continue medical benefits under such applicable law. Non-medical benefits shall be continued according to the established Company policy. Participants continuing participation pursuant to the foregoing shall pay for such coverage (on a pre-tax or after-tax basis) under a method as determined by the Plan Administrator satisfying Treas. Reg. 1.125-3 Q&A-3. Any Participant on FMLA leave who revoked coverage shall be reinstated to the extent required by Treas. Reg. 1.125-3. If the Participant's coverage under the Plan terminates while the Participant is on FMLA leave, the Participant is not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. Upon reinstatement into the Plan upon return from FMLA leave, the Participant has the right to (i) resume coverage at the level in effect before the FMLA leave and make up the unpaid premium payments, or (ii) resume coverage at a level that is reduced by the amount of unpaid premiums and resume premium payments at the level in effect before the FMLA leave. The Plan Administrator shall also permit Participants to continue benefit elections as required under the Uniformed Services Employment and

Reemployment Rights Act and shall provide such reinstatement rights as required by such law. The Plan Administrator shall also permit Participants to continue benefit elections as required under any other applicable state law to the extent that such law is not pre-empted by federal law.

Section 3.04 COBRA

To the extent the Plan is subject to COBRA (Code section 4980B and other applicable state law), a Participant shall be entitled to continuation coverage with respect to his or her health benefits as prescribed in Code section 4980B (and the regulations thereunder) or such applicable state statutes.

Section 3.05 THIRD PARTY RECOVERY/REIMBURSEMENT

(a) The Plan Administrator may, but is not required to, utilize the provisions of this subsection to the extent not inconsistent with the provisions of any applicable Subsidiary Contract, in which case the provisions of the Subsidiary Contract shall control.

(b) In General. When a Participant or covered dependent receives Plan benefits which are related to medical expenses that are also payable under Workers' Compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, the Participant shall reimburse the Plan for the related Plan benefits received out of any funds or monies the Participant recovers from any third party.

(c) Specific Requirements and Plan Rights. Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that a Participant or covered dependent may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, and even if the Participant or covered dependent has not been paid or fully reimbursed for all of their damages or expenses.

The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring the Participant to assert a claim to any of the benefits to which the Participant or a covered dependent may be entitled. The Plan will not pay attorneys' fees or costs associated with the claim or lawsuit without express written authorization from the Company.

If the Plan should become aware that a Participant or covered dependent has received a third party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to the Participant and covered dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of the Participant or covered dependents.

(d) Participant Duties and Actions. By participating in the Plan each Participant and covered dependent consents and agrees that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, each Participant and covered dependent agrees to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once a Participant or covered dependent has any reason to believe that the Plan may be entitled to recovery from any third party, the Participant must notify the Plan. And, at that time, the Participant (and the Participant's attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle the Participant or covered dependent to any payment, amount or recovery from a third party.

If a Participant fails or refuses to execute the required subrogation/ reimbursement agreement, the Plan may deny payment of any benefits to the Participant or covered dependent until the agreement is signed. Alternatively, if a Participant fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of the Participant or a covered dependent, the Participant's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

Each Participant and covered dependent consents and agrees that they shall not assign their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

Section 3.06 HIPAA PORTABILITY RULES

To the extent the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules, the Plan shall comply with the requirements of Code section 9801 et. seq. including the requirement to cover children until the attainment of at least age 26 if the Plan makes dependent coverage of children available.

ARTICLE 4: FUNDING

Section 4.01 NO FUNDING REQUIRED

Except as otherwise required by law:

(a) Any amount contributed by a Participant and/or the Company to provide benefits hereunder shall remain part of the general assets of the Company and all payments of benefits under the Plan shall be made out of the general assets of the Company or the Subsidiary Contracts.

(b) The Company shall have no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. However, the Company may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making any benefit payments under this Plan.

(c) No person shall have any rights to, or interest in, any account other than as expressly authorized in the Plan.

Section 4.02 FUNDING POLICY

The Company shall have the right to enter into a contract with one or more Subsidiary Contract providers for the purposes of providing any benefits under the Plan and to replace any of such Subsidiary Contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such Subsidiary Contract shall not be assets of the Plan but shall be the property of, and shall be retained by the Company. The Company will not be liable for any loss or obligation relating to any insurance coverage except as is expressly provided by this Plan. Such limitation shall include, but not be limited to, losses or obligations that pertain to the following:

(a) Once a Subsidiary Contract is applied for or obtained, the Company will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Company;

(b) To the extent premium notices are received by the Company, the Company's liability for the payment of such premiums will be limited to such premiums and will not include liability for any other loss which result from such failure;

(c) When employment ends, the Company will have no liability to take any step to maintain any policy in force except as may be specifically required otherwise in this Plan and the Company will not be liable for or responsible to see to the payment of any premium with respect to periods after employment ends.

ARTICLE 5: CLAIMS PROCEDURES

Section 5.01 CLAIMS PROCEDURES

(a) This Section 5.01 shall apply for any claim for benefits under a Subsidiary Contract unless the Subsidiary Contract has a claims procedure that is compliant with ERISA section 503. If the Subsidiary Contract has a claims procedure that is compliant with ERISA section 503, the claims procedure of the Subsidiary Contract shall apply.

A request for benefits is a "claim" subject to these procedures only if it is filed by the Participant or the Participant's authorized representative in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable Subsidiary Contract provider. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that the inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to process the claim, the Participant will be given an opportunity to provide the missing information.

Participants may designate an authorized representative if written notice of such designation is provided to the applicable provider identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of the Participant's medical condition may act as an authorized representative with or without prior notice.

(b) Timing of Notice of Claim. The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than the time frame below, depending on the type of benefit being provided under the Subsidiary Contract under which the claim for benefits arises.

(i) In General. Notice will be provided within 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(ii) Group Health Plan Claims. The timeframe for benefit determinations under group health plans shall be determined as provided under DOL Reg. section 2560.503-1(f)(2). For purposes of this Section 5.01, group health plan means a group health plan as defined in DOL Reg. section 2560.503-1(m)(6).

(iii) Disability Plan Claims (or Claims Involving Disability).Notice will be provided 45 days after receipt of the claim. This period may be extended by the Plan for up to 30 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The period for making the determination may be extended for up to an additional 30 days if Plan Administrator notifies the claimant prior to the expiration of the first 30-day extension period the circumstances of the extension and the date by which the Plan expects to render a decision. Any notice extension under this section shall explain the standards on which the entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

(c) Content of Notice of Denied Claim.

(i) If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a written notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, and (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA.

(ii) In addition, if the wholly or partially denied claim is by a Subsidiary Contract providing group health or disability benefits, the following information must also be included in the written notice: (1) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or (2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the

scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(iii) In the case of a wholly or partially denied claim involving urgent care (as defined in DOL Reg. section 2560.503-1(m)(1)) under a Subsidiary Contract providing group health benefits, the notice must include a description of the expedited review process applicable to such claims. In addition, the information described in this Section 5.01(c) may be provided orally within the timeframe required under Section 5.01(b) provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

(d) Appeal of Denied Claim.

(i) If a Claimant wishes to appeal the denial of a claim, he shall file a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied (the 180th day for claims involving a group health plan or disability benefits). The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall lose the right to appeal if the appeal is not timely made.

(A) The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. A written appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant.

(B) In addition to the requirements of paragraph (A) above, if the claim is under a Subsidiary Contract providing group health or disability benefits, the claims procedures shall be determined in accordance with DOL Reg. section 2560.503-1(h)(3) and 2560.503-1(h)(4).

(ii) The Plan Administrator shall ordinarily rule on an appeal within 60 days. However, if special circumstances require an extension and the Plan Administrator furnishes the Claimant with a written extension notice during the initial period, the Plan Administrator may take up to 120 days to rule on an appeal. If the denied claim is by a Subsidiary Contract providing group health or disability benefits, the timing of the Plan Administrator's review shall be determined in accordance with DOL Reg. section 2560.503-1(i)(2) and 560.503-1(i)(3).

(e) Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) 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, and (4) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator shall be binding upon all parties. In addition, if the claim is under a Subsidiary Contract providing group health or disability benefits, the denial notice shall include additional information required under DOL Reg. section 2560.503-1(j)(5).

(f) Exhaustion of Remedies. Before a suit can be filed in federal court, claims must exhaust internal remedies.

(g) Additional Claims Processes.

(i) Applicability. This Subsection shall apply to the extent (1) the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules and (2) the Plan is not a grandfathered health plan under the Patient Protection and Affordable Care Act.

(ii) Effective Date. This Subsection shall be effective the later of the first plan year beginning after September 23, 2010 or the date the Plan is no longer a grandfathered health plan under the Patient Protection and Affordable Care Act.

(iii) Internal Claims Process. The claims requirements above shall apply as the internal claims process except as provided under DOL Reg. 2590.715-2719 and any superseding guidance.

(1) Adverse Benefit Determination. An adverse benefit determination means an adverse benefit determination as defined in DOL Reg. 2560.503-1, as well as any rescission of coverage, as described in DOL Reg. 2590.715-2712(a)(2).

(2) Expedited Urgent Care Determinations. The requirements of DOL Reg. section 2560.503-1(f)(2)(i) apply as provided in DOL Reg. 2590.715-2719(b)(2)(ii)(B) and any superseding guidance. Claimants must be notified of benefit determinations (whether adverse or not) with respect to a claim involving urgent care (as defined in DOL Reg. section 2560.503-1(m)(1)) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim.

(3) Full and Fair Review. A Claimant must be allowed to review the file and present evidence and testimony as part of the internal appeals process. Claimants must be provided, free of charge, with any new or additional evidence considered relied upon or generated by the Plan in connection with the claim sufficiently in advance of the final adverse benefit determination to give the Claimant a reasonable opportunity to respond prior to that date. The Plan must also meet the conflict of interest requirements under DOL Reg. 2590.715-2712(b)(2)(D).

(4) Notice. A description of available internal and external claims processes and information regarding how to initiate an appeal must be provided. Notices of adverse benefit determinations must include the information required under DOL Reg. 2590.715-2719(b)(2)(ii)(E) as applicable. The final notice of internal adverse benefit determination must include a discussion of the decision. Notice must be provided in a linguistically appropriate manner as provided under DOL Reg. 2590.715-2719(e). The Plan must disclose the contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(5) Deemed Exhaustion of Internal Claims Process. If the Plan fails to adhere to the requirements of DOL Reg. 2590.715-2719(b)(2), except as provided under DOL Reg. 2590.715-2719(b)(2)(ii)(F)(2), the claimant may initiate an external review under Section 6.02(b)(2) or may bring an action under section 502(a) of ERISA as provided in DOL Reg. 2590.715-2719(b)(2)(ii)(F) and any superseding guidance.

(iv) External Claims Process.

(1) State Process. To the extent the Plan is required under DOL Reg. section 2590.715-2719(c)(1)(i) or (c)(1)(ii) to comply with a State external claims process that includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the plan or issuer must comply with the state external claims process of DOL Reg. section 2590.715-2719(c).

(2) Federal Process. To the extent the Plan is not required under DOL Reg. section 2590.715-2719(c)(1)(i) or (c)(1)(ii) to comply with the State external claims process, then the plan or issuer must comply with the Federal external claims process of DOL Reg. section 2590.715-2719(d) and any superseding guidance.

Section 5.02 MINOR OR LEGALLY INCOMPETENT PAYEE

If a distribution is to be made to an individual who is either a minor or legally incompetent, the Plan Administrator may direct that such distribution be paid to the legal guardian. If a distribution is to be made to a minor and there is no legal guardian, payment may be made to a parent of such minor or a responsible adult with whom the minor maintains his residence, or to the custodian for such minor under the Uniform Transfer to Minors Act, if such is permitted by the laws of the state in which such minor resides. Such payment shall fully discharge the Plan Administrator and the Company from further liability on account thereof.

Section 5.03 MISSING PAYEE

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to

such Participant or other person shall be forfeited one year after the date any such payment first became due.

ARTICLE 6: AMENDMENT OR TERMINATION OF PLAN

Section 6.01 AMENDMENT

The provisions of the Plan may be amended in writing at any time and from time to time by the Plan Sponsor.

Section 6.02 TERMINATION

(a) It is the intention of the Plan Sponsor that this Plan will be permanent. However, the Plan Sponsor reserves the right to terminate the Plan at any time for any reason.

(b) Each entity constituting the Company reserves the right to terminate its participation in this Plan. In addition, each such entity constituting the Company shall be deemed to terminate its participation in the Plan if: (i) it is a party to a merger in which it is not the surviving entity and the surviving entity is not an affiliate of another entity constituting the Company, or (ii) it sells all or substantially all of its assets to an entity that is not an affiliate of another entity constituting the Company.

(c) Upon termination, any assets remaining in the Plan shall be used to pay outstanding benefit claims. To the extent permitted by the Subsidiary Contracts and to the extent the assets do not revert to the Company, any remaining assets shall be refunded to Participants.

ARTICLE 7: GENERAL PROVISIONS

Section 7.01 NONALIENATION OF BENEFITS

No Participant or Beneficiary shall have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which he may expect to receive, contingently or otherwise, under the Plan.

Section 7.02 NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan shall be construed as a contract of employment between the Company and the Participant, or as a right of any employee to continue in the employment

of the Company, or as a limitation of the right of the Company to discharge any of its employees, with or without cause.

Section 7.03 GOVERNING LAW

(a) The Plan shall be construed in accordance with and governed by the laws of the state or commonwealth of organization of the Plan Sponsor to the extent not preempted by Federal law.

(b) The Plan hereby incorporates by reference any provisions required by state law to the extent not preempted by Federal law.

Section 7.04 TAX EFFECT

The Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. A Participant should consult with professional tax advisors to determine the tax consequences of his or her participation.

Section 7.05 SEVERABILITY OF PROVISIONS

If any provision of the Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and the Plan shall be construed and enforced as if such provisions had not been included.

Section 7.06 HEADINGS AND CAPTIONS

The headings and captions herein are provided for reference and convenience only, shall not be considered part of the Plan, and shall not be employed in the construction of the Plan.

Section 7.07 GENDER AND NUMBER

Except where otherwise clearly indicated by context, the masculine and the neuter shall include the feminine and the neuter, the singular shall include the plural, and vice-versa.

Section 7.08 EFFECT OF MISTAKE

In the event of a mistake as to the eligibility or participation of an employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such

action by the Administrator may include withholding of any amounts due the Plan or the Company from Compensation paid by the Company.

ARTICLE 8: HIPAA

The Plan will comply with the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA") as set forth below.

Section 8.01 DEFINITIONS

For purposes of this Article 8, the following terms have the following meanings:

(a) "Business Associate" means any outside vendor who performs a function or activity on behalf the Plan which involves the creation, use or disclosure of PHI, and includes any subcontractor to whom a Business Associate delegates its obligations.

(b) "Group Health Benefits" means the medical benefits, dental benefits, vision benefits and, if applicable, employee assistance program benefits offered under the Plan.

(c) "Individual" means the Participant or the Participant's covered dependents enrolled in any of the Group Health Benefits under the Plan.

(d) "Notice of Privacy Practices" means a notice explaining the uses and disclosures of PHI that may be made by the Plan, the covered Individuals' rights under the Plan with respect to PHI, and the Plan's legal duties with respect to PHI.

(e) "Plan Administration Functions" means the administration functions performed by the Plan Sponsor on behalf of the Plan. Plan Administration Functions do not include functions performed by the Plan Sponsor in connection with any other benefit plan of the Plan Sponsor.

(f) "Protected Health Information ("PHI")" means information about an Individual, including genetic information, (whether oral or recorded in any form or medium) that:

(1) is created or received by the Plan or the Plan Sponsor;

(2) relates to the past, present or future physical or mental health or condition of the Individual, the provision of health care to the Individual, or the past, present or future payment for the provision of health care to the Individual; and

(3) identifies the Individual or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual.

PHI includes Protected Health Information that is transmitted by or maintained in electronic media.

(g) "Summary Health Information" means information summarizing the claims history, claims expenses, or types of claims experienced by an Individual, and from which the following information has been removed:

(1) names;

(2) any geographic information which is more specific than a five digit zip code;

(3) all elements of dates relating to a covered Individual (e.g., birth date) or any medical treatment (e.g., admission date) except the year; all ages for a covered Individual if the Individual is over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);

(4) other identifying numbers, such as, Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;

(5) facial photographs or biometric identifiers (e.g., finger prints); and

(6) any other unique identifying number, characteristic, or code.

Section 8.02 HIPAA PRIVACY COMPLIANCE

The Plan's HIPAA privacy compliance rules ("Privacy Rule") are as follows:

(a) Permitted Use or Disclosure of PHI by Plan Sponsor. Any disclosure to and use by the Plan Sponsor of any PHI will be subject to and consistent with this Section.

(1) The Plan and health insurance issuer, HMO, or Business Associate servicing the Plan may disclose PHI to the Plan Sponsor to permit the Plan Sponsor to carry out Plan Administration Functions, including but not limited to the following purposes:

(A) to provide and conduct Plan Administrative Functions related to payment and health care operations for and on behalf of the Plan;

(B) for auditing claims payments made by the Plan;

(C) to request proposals for services to be provided to or on behalf of the Plan; and

(D) to investigate fraud or other unlawful acts related to the Plan and committed or reasonably suspected of having been committed by a Plan participant.

(2) The uses described above in (1) are permissible only if the Notice of Privacy Practices distributed to covered Individuals in accordance with the Privacy Rule states that PHI may be disclosed to the Plan Sponsor.

(3) The Plan or a health insurance issuer or HMO may disclose to the Plan Sponsor information regarding whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(b) Restrictions on Plan Sponsor's Use and Disclosure of PHI.

(1) The Plan Sponsor will not use or further disclose PHI, except as permitted or required by the Plan or as required by law.

(2) The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides PHI agrees to the restrictions and conditions of this Section.

(3) The Plan Sponsor will not, and will not permit a health insurance issuer or HMO to, use or disclose PHI for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(4) The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures allowed under this Section promptly upon learning of such inconsistent use or disclosure.

(5) The Plan Sponsor will make a covered Individual's PHI available to the covered Individual in accordance with the Privacy Rule.

(6) The Plan Sponsor will make PHI available for amendment and will, upon notice, amend PHI in accordance with the Privacy Rule.

(7) The Plan Sponsor will track certain PHI disclosures it makes so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with the Privacy Rule.

(8) The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of PHI received from the Plan to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with the Privacy Rule.

(9) The Plan Sponsor will, if feasible, return or destroy all PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or

control) received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Individual who is the subject of the PHI, when that PHI is no longer needed for the Plan Administration Functions for which the disclosure was made. If it is not feasible to return or destroy all such PHI, the Plan Sponsor will limit the use or disclosure of any PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

(10) When using or disclosing PHI or when requesting PHI from another party, the Plan sponsor must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure, and limit any request for PHI to the minimum necessary to satisfy the purpose of the request.

(11) The Plan Sponsor will not use any genetic information for any underwriting purposes.

(c) Adequate Separation between the Plan Sponsor and the Plan.

(1) Only those employees of the Plan Sponsor, as outlined in the Plan's HIPAA Policies and Procedures, may be given access to PHI received from the Plan or a health insurance issuer, HMO or Business Associate servicing the Plan.

(2) The members of the classes of employees identified in the Plan's HIPAA Policies and Procedures will have access to PHI only to perform the Plan Administration Functions that the Plan Sponsor provides for the Plan.

(3) The Plan Sponsor will promptly report to the Plan any use or disclosure of PHI in breach, violation of, or noncompliance with, the provisions of this Section of the Plan, as required under this Section, and will cooperate with the Plan to correct the breach, violation or noncompliance, will impose appropriate disciplinary action or sanctions, including termination of employment, on each employee who is responsible for the breach, violation or noncompliance, and will mitigate any deleterious effect of the breach, violation or noncompliance on any Individual covered under the Plan, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance. Regardless of whether a person is disciplined or terminated pursuant to this section, the Plan reserves the right to direct that the Plan Sponsor, and upon receipt of such direction the Plan Sponsor shall, modify or revoke any person's access to or use of PHI.

(d) Purpose of Disclosure of Summary Health Information to Plan Sponsor.

(1) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan.

(2) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

(e) Plan Sponsor Certification. The Plan Sponsor will provide the Plan with a certification stating that the Plan has been amended to incorporate the terms of this Article and that the Plan Sponsor agrees to abide by these terms. The Plan Sponsor will also provide the certification upon request to its health insurance issuers, HMOs and Business Associates of the Plan.

(f) Rights of Individuals.

(1) Notice of Privacy Practices. The Plan Sponsor will provide a Notice of Privacy Practices to the Participant in accordance with HIPAA.

(2) Right to Request Restrictions. Each Individual has the right to request that the Plan restrict its uses and disclosures of the Individual's PHI.

(3) Right to Access. Each Individual has the right to obtain and inspect its PHI held by the Plan.

(4) Right to Amend. Each Individual has the right to ask the Plan to amend its PHI.

(5) Right to an Accounting. Each Individual has the right to request an accounting of disclosures of PHI made by the Plan for purposes other than treatment, payment or health care operations.

Section 8.03 HIPAA SECURITY COMPLIANCE

To ensure the Plan's compliance with HIPAA's privacy compliance rules ("Security Rule"), the Plan Sponsor will:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Ensure that the adequate separation required by the HIPAA Security Rule is supported by reasonable and appropriate security measures;

(c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

(d) Report to the Plan any security incident of which it becomes aware.

Section 8.04 HIPAA COMPLIANCE FOR FULLY INSURED GROUP HEALTH BENEFITS

Notwithstanding the foregoing, to the extent any of the Plan's Group Health Benefits are fully insured, the Plan Sponsor has adopted a policy of not receiving, disclosing or using PHI or Summary Health Information regarding insured benefits for any purpose permitted under HIPAA, unless authorized by the Individual, when appropriate.

The Plan Sponsor caused this Plan to be executed this _____ day of _____, 2016.

BLACKWATER COMMUNITY SCHOOL:

Signature:_____

Print Name: _____

Title/Position:_____

SUBSIDIARY CONTRACTS ADDENDUM

"Subsidiary Contract" means any agreement, writing, contract, plan or arrangement between the Company and the following benefit provider(s) for the benefit(s) indicated:

Blackwater Community School Self-Funded Medical Plan-TPA Summit - Major Medical
Principal - Dental
Principal - Vision
Principal - Life/AD&D
Principal - Short-Term Disability
Principal - Employee Assistance Plan

AFFORDABLE CARE ACT (ACA) ELIGIBILITY ADDENDUM

Effective October 1, 2015, the following Eligibility provisions apply only with respect to eligibility for medical benefits under the Plan. To the extent that this Section conflicts with any provision in the Plan or a subsidiary Contract, the terms of this Section shall control.

ACA 1.01 APPLICABLE DEFINITIONS

"Administrative Period" means the time allowed during which employees can enroll in or disenroll from medical benefits coverage under the Plan. The Administrative Period for Ongoing Employees starts on **May 1** and ends on **June 30**. The Administrative Period for new employees is the two full calendar months following the end of the Initial Measurement Period.

"Break in Service" means, following an employee's termination of employment, a period of 13 or more consecutive weeks during which the employee did not have an hour of service. If the employee had not been employed for at least 13 weeks prior to his termination of employment, a Break in Service means a period of four or more consecutive weeks during which the employee did not have an hour of service, where such period is greater than the employee's period of employment.

"Full-time Employee" is an Employee who is reasonably expected to work, on average, at least 30 hours per week or 130 hours per calendar month.

"Initial Measurement Period" means the period of time during which a new employee's hours of service are measured to determine whether the employee is a Full-time Employee. The Initial Measurement Period is **12 months long**. The Initial Measurement Period starts on **the first day of the first calendar month following employee's date of hire**.

"Ongoing Employee" means an employee who has been employed by the Company for at least one complete Standard Measurement Period.

"Part-time Employee" means a new employee who the Company reasonably expects to work, on average, less than 30 hours per week during the Initial Measurement Period.

"Seasonal Employee" means an employee who is hired into a position for which the customary annual employment period is six months or less and which begins at approximately the same time of each calendar year.

"Stability Period" means the period of time during which an employee is treated as a Full-time Employee for purposes of determining eligibility for medical benefits under the Plan. The Stability Period is **12 months long.** For Ongoing Employees this period starts **July 1** and ends **June 30**.

"Standard Measurement Period" means the period during which the Company counts an employee's hours of service. The Standard Measurement Period is **12 months long**. The Standard Measurement Period starts on **May 1** and ends on **April 30**.

"Variable Hour Employee" means an employee for whom the Company cannot determine, at the employee's hire date, whether the employee is reasonably expected to work an average of at least 30 hours per week.

ACA 2.01 ELIGIBILITY

The Company offers medical benefits coverage to Full-time Employees, their dependent children and/or spouses. Dependent children and spouses are defined in the separate subsidiary Contracts for medical benefits.

Effective **October 1, 2015**, the Company will use the following Measurement Period(s) to determine whether an employee is a Full-time Employee for purposes of medical benefits coverage under the Plan:

Look-Back Measurement Period

Look-Back Measurement Period

The Company intends to follow IRS regulations and any subsequent guidance when administering the Look-Back Measurement Period.

a) *Ongoing Employees*

For Ongoing Employees, the Company will determine whether an individual is a Full-time Employee by looking at the employee's hours of service during the Standard Measurement Period. If an Ongoing Employee is a Full-time Employee during the Standard Measurement Period, he or she will be eligible for medical benefits under the Plan during the entire Stability Period. The employee will remain eligible for medical benefits during the entire Stability Period, regardless of the employee's actual number of hours of service during the Stability Period, as long as he remains an employee of the Company. Similarly, if an employee is not a Full-time Employee during the Standard Measurement Period, he will not be eligible for medical benefits during the entire Stability Period.

b) *New Employees Expected to Work Full Time*

If the Company reasonably expects a new employee to be a Full-time Employee as of the employee's hire date, the Company will determine the employee's status as a Full-

time Employee using the employee's hours of service for each calendar month. If the employee's hours of service average at least thirty (30) hours per week or one hundred thirty (130) hours per month, the employee will be offered medical benefits coverage under the Plan pursuant to the standard eligibility and enrollment waiting periods required by the Plan, as detailed in the relevant Subsidiary Contract.

c) *New Part-time, Seasonal or Variable Hour Employees*

Newly hired Part-time, Seasonal and Variable Hour Employees must first complete an Initial Measurement Period during which they are not eligible to enroll in medical benefits under the Plan. At the end of the Initial Measurement Period, if the employee is a Full-time Employee, that employee will be eligible for medical benefits under the Plan as of completion of Measurement and Administrative Periods, and for the Stability Period.

Enrollment

The Company will use the Administrative Period to determine whether an employee is a Full-time Employee and to offer coverage to those Full-time Employees during an open enrollment period. Medical benefits coverage will be effective during the Stability Period.

ACA 3.01 BREAK IN SERVICE

An employee who was enrolled in medical benefits coverage under the Plan on the date of his termination of employment may resume participation in the medical benefits under the Plan on **the employee's date of rehire** if the employee has not had a Break in Service (provided that for any Look-back measurement, that the Stability period on the date of reemployment is the same as the Stability Period in effect on the date of the individual's prior termination of employment. If reemployment begins during a new Stability Period, participation in the medical benefit under the Plan will begin on this date if, based on the applicable Measurement Period, the individual is a Full-time Employee on the date of reemployment).

If the employee had not satisfied any applicable waiting period prior to his termination of employment, upon rehire, the waiting period will be reduced by the period of prior employment.

If the employee is reemployed after a Break in Service, eligibility to become a participant in the medical benefits under the Plan will be based on the individual's status on the date of rehire.

BLACKWATER COMMUNITY SCHOOL WRAP PLAN

SUMMARY PLAN DESCRIPTION

October 1, 2015

BLACKWATER COMMUNITY SCHOOL WRAP PLAN
SUMMARY PLAN DESCRIPTION

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INTRODUCTION

Blackwater Community School (the "Company") established the **Blackwater Community School Wrap Plan** (the "Plan") effective **October 1, 2015**.

Although the purpose of this document is to summarize the more significant provisions of the Plan, the Plan document will prevail in the event of any inconsistency.

OTHER SUMMARY PLAN DESCRIPTIONS AND PLAN INFORMATION

This Plan incorporates the terms of all welfare benefit plans provided or administered by the insurance provider(s), third-party administrator(s) and/or vendor(s) listed in Appendix A, and sponsored by Blackwater Community School or any affiliate who has adopted the Plan.

You should receive separate Summary Plan Descriptions and/or booklets or certificates from each of the welfare benefit plans described above. In these documents you should find information about eligibility, benefits and employee/employer contributions for each of the separate welfare benefit plans. You are eligible to participate in this Plan if you are eligible to participate in one of the welfare benefit plans described above. In addition, in general, all benefits of this Plan are provided by the welfare benefit plans described above.

This Summary Plan Description incorporates the terms of the other Summary Plan Descriptions, insurance certificates and/or membership booklets currently valid for each of the welfare benefit plans described above. This Summary Plan Description supersedes all previous Blackwater Community School Wrap Plan Summary Plan Descriptions, if any.

You can find a summary of the eligibility requirements and the employer/employee contributions for the welfare benefit plans mentioned above in "APPENDIX A: WELFARE BENEFIT PLAN CHART" at the end of the document.

CLAIMS

Refunds/Indemnification

You must immediately repay any excess payments/reimbursements. You must reimburse the Company for any liability the Company may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

Third Party Recovery

If you are paid benefits from another welfare benefit plan the Plan may be entitled to reimbursement. In particular, the plan may be entitled to reimbursement for benefits which are related to medical expenses that are also payable under Workers' Compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason.

By participating in the Plan you and your covered dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance, you and your covered dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses. If you or your covered dependents have any reason to believe that the Plan may be entitled to recovery from any third party, you must notify the Plan. And, at that time, you (and your attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle the Participant or covered dependent to any payment, amount or recovery from a third party.

You and your covered dependent consent and agree that you will not assign your rights to settlement or recovery against a third person or party to any other party, including your attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

Claim Procedures - In General

This section applies for any claim for benefits under a welfare benefit plan that is covered by ERISA unless the welfare benefit plan has a claims procedure that is compliant with ERISA section 503. If the welfare benefit plan has a claims procedure that is compliant with ERISA section 503, the claims procedure of the welfare benefit plan will apply. In general, this means that if the claims procedure of the welfare benefit plan has timeframes and procedures that are at least as favorable to you or more favorable than the deadlines provided below, the claims procedure of the welfare benefit plan will apply. In the case of a group health plan, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures are described in the relevant SPD for that plan and incorporated herein.

You or any other person entitled to benefits from the welfare benefit plan (a "Claimant") may apply for such benefits by completing and filing a claim with the applicable welfare benefit plan provider in accordance with the provider's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable welfare benefit plan provider. Any claim that does not relate to a specific

benefit under the plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the welfare benefit plan's plan administrator. Any claim must include all information and evidence that the welfare benefit plan provider or plan administrator (the "Claim Reviewer") deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. If a claim is received, but there is not enough information to process the claim, you will be given an opportunity to provide the missing information.

A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim.

If you want to bring a claim for benefits under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the applicable provider identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of your medical condition may act as your authorized representative with or without prior notice.

Timing of Notice of Claim

The Claim Reviewer will notify the Claimant of any benefit determination within a reasonable period of time but not later than the timeframe specified below depending on the type of claim.

Group Health Plan Claims

Group health plan claims may involve urgent care, concurrent care claims, pre-service care claims or post-service claims. Each has different time-frames that may apply and is described below.

Urgent Care. The Claim Reviewer will notify the Claimant of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. In the case of such a failure, the Claim Reviewer will notify the Claimant as soon as possible, but not later than 72 hours after receipt of the claim, of the specific information necessary to complete the claim. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claim Reviewer will notify the Claimant of the determination as soon as possible, but in no case later than 48 hours after the earlier of (A) the plan's receipt of the specified information, or (B) the end of the period afforded the Claimant to provide the specified additional information.

Concurrent care (a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments). The welfare benefit plan will notify a Claimant of any reduction or termination of a course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care that will be decided as soon as possible, taking into account the medical exigencies, and the Claim Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 72 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Pre-service claims. The Claim Reviewer will notify the Claimant of the plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan. This period may be extended one time by the plan for up to 15 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Reviewer expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Post-service claims. The Claim Reviewer will notify the Claimant, of an adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Disability Claims

In the case of a claim for disability benefits, the Claim Reviewer will notify the Claimant, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the

expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Claim Reviewer notifies the Claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. The notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the Claimant will be afforded at least 45 days within which to provide the specified information.

Other Claims

The Claim Reviewer will notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial review period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Content of Notice of Denied Claim

If a claim is wholly or partially denied, the Claim Reviewer will provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA.

In addition to the above information, if it is a group health plan or a plan providing disability benefits, the following information must be included with the notice described above:

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or

(B) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical

circumstances, or a statement that such explanation will be provided free of charge upon request.

In addition, in the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims must be included with the notice described above and may be provided to the Claimant orally within the time frame described above, provided that a written or electronic notification is furnished to the Claimant not later than 3 days after the oral notification.

Appeal of Denied Claim

If a Claimant wishes to appeal the denial of a claim, he must file an appeal with the Claim Reviewer on or before the 180th day (or the 60th day in the case of a claim other than a group health plan benefit or a disability benefit) after he receives the Claim Reviewer's notice that the claim has been wholly or partially denied. The appeal will identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant will be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Claim Reviewer will consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Claim Reviewer may deem relevant. The Claimant will lose the right to appeal if the appeal is not timely made.

In considering the appeal of a group health plan benefit or a disability benefit, the Claim Reviewer will:

(1) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(2) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(3) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(4) Provide that the health care professional engaged for purposes of a consultation under Subsection (2) will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

(5) In addition, in the case of a claim involving urgent care, provide for an expedited review process pursuant to which (A) a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Claimant; and (B) all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

Notice of Denied Appeal Review

Except as provided below for group health urgent care, pre-service and post-service claims, the Claim Reviewer will notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination (45 days in the case of a claim involving disability benefits). If the Claim Reviewer determines that an extension of time for processing is required, written notice of the extension will be furnished to the Claimant prior to the termination of the initial 60-day period (45 days in the case of a claim involving disability benefits). In no event will such extension exceed a period of 60 days from the end of the initial period (45 days in the case of a claim involving disability benefits). The extension notice will indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

Urgent care claims. In the case of a claim involving urgent care, the Claim Reviewer will notify the Claimant of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an adverse benefit determination by the plan.

Pre-service claims. In the case of a pre-service claim, the Claim Reviewer will notify the Claimant, of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification will be provided not later than 30 days after receipt by the plan of the Claimant's request for review of an adverse benefit determination.

Post-service claims. The Claim Reviewer will notify the Claimant of the plan's benefit determination on review within a reasonable period of time. Such notification will be provided not later than 60 days after receipt by the plan of the Claimant's request for review of an adverse benefit determination.

CONTINUATION RIGHTS

Continuation Rights Generally

In certain instances, you or your dependents may be entitled, under state or federal law, to continue some or all of your benefits under this Plan after termination of employment or during a qualified leave of absence. Contact the Company for more information.

Military Service

If you serve in the United States Armed Forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

FMLA

If you go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving benefits.

COBRA

Under Federal law, you, your spouse, and your dependents may be entitled to COBRA continuation coverage in certain circumstances. The Plan Administrator will inform you of these rights, if any, when you terminate employment. Please see the INITIAL COBRA NOTICE that is attached to the end of this Summary Plan Description for important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The COBRA NOTICE generally explains COBRA continuation coverage and when it may become available to you.

YOUR RIGHTS UNDER ERISA

As a participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). This federal law provides that you have the right to:

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements (if applicable), updated summary plan descriptions, and, for a Plan covering 100 or more participants, copies of the latest annual report (Form 5500 Series). The Plan Administrator may make a reasonable charge for the copies.

For Plans covering 100 or more employee participants, receive a summary of the Plan's annual financial report. The Plan Administrator for such plans is required by law to furnish each participant with a copy of this summary annual report.

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. (Certificates of creditable coverage are no longer required after December 31, 2014.)

In addition, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining your benefits or exercising your rights under ERISA.

If your claim for a 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 you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report 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 Plan Administrator to provide the materials and pay you up to $110 a 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, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in 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.

If you have any questions about the Plan, you should contact the Plan Administrator. 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 Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or 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.

MISCELLANEOUS

Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO). You may obtain a copy of the QMCSO procedures from the Plan Administrator, free of charge.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you or your dependents become ineligible for Medicaid or a state child health program (CHIP) or become eligible for premium assistance under Medicaid or a state child health program (CHIP), you must request enrollment within 60 days. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your Plan Administrator at the number provided at the end of this Summary Plan Description.

Newborns' And Mothers' Health Protection

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

Loss of Benefit

You may lose all or part of any payment due to you if we cannot locate you when your benefit becomes payable to you.

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a Beneficiary.

Amendment and Termination

The Company may amend, terminate or merge the Plan at any time.

Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding.

Taxation

The Company intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, the Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

Privacy

The Plan is required under federal law to take sufficient steps to protect any individually identifiable health information to the extent that such information must be kept confidential. The Plan Administrator will provide you with more information about the Plan's privacy practices.

ADMINISTRATIVE INFORMATION

1. The Plan Sponsor and Plan Administrator is **Blackwater Community School**.

   Its address is **3652 E. Blackwater School Rd, Coolidge, AZ 85128**.

   Its telephone number is **(520) 215-5859**

   Its Employer Identification Number is **86-0797149**.

2. The Plan is a welfare benefit plan which has been designated by the sponsor as its plan number is **501**.

3. The Plan's designated agent for service of legal process is the chief officer of the entity named in number 1. Any legal papers should be delivered to him or her at the address listed in number 1. However, service may also be made upon the Plan Administrator.

4. The Company's fiscal year ends on **June 30** and the plan year ends on **June 30**.

INITIAL COBRA NOTICE

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

The end of employment or reduction of hours of employment; Death of the employee; The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Company at 3652 E. Blackwater School Rd, Coolidge, AZ 85128. The Company's telephone number is (520) 215-5859.

How is COBRA Continuation Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the

nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information for COBRA Administration:

Summit
ATTN: Michelle McGowan
14646 N. Kierland Blvd., Suite 200
Scottsdale, AZ 85254
michelle@summit-inc.net
(480) 505-0392

APPENDIX A: WELFARE BENEFIT PLAN CHART

Standard Eligibility Requirements (applied to all benefits listed in chart below): All Employees except Part-time Employees, expected to work less than thirty (30) hours per week are eligible on the first day of the month following sixty (60) days after date of hire.

Eligibility information relating to medical coverage offered under this Plan is further specified in the ACA Eligibility Addendum.

Provider	Type of Benefit	Employer Contributions	Eligibility
Blackwater Community School Self-Funded Medical Plan-TPA Summit	Major Medical	See Human Resources for Cost Information	See 'Standard Eligibility Requirements' set forth above
Principal	Dental	See Human Resources for Cost Information	See 'Standard Eligibility Requirements' set forth above
Principal	Vision	See Human Resources for Cost Information	See 'Standard Eligibility Requirements' set forth above
Principal	Life/AD&D	See Human Resources for Cost Information	See 'Standard Eligibility Requirements' set forth above
Principal	Short-Term Disability	See Human Resources for Cost Information	See 'Standard Eligibility Requirements' set forth above
Principal	Employee Assistance Plan	See Human Resources for Cost Information	See 'Standard Eligibility Requirements' set forth above

AFFORDABLE CARE ACT (ACA) ELIGIBILITY ADDENDUM

Effective October 1, 2015, the following Eligibility provisions apply only with respect to eligibility for medical benefits under the Plan. To the extent that this Section conflicts with any provision in the Plan or a subsidiary Contract, the terms of this Section shall control.

Applicable Definitions

"Administrative Period" means the time allowed during which employees can enroll in or disenroll from medical benefits coverage under the Plan. The Administrative Period for Ongoing Employees starts on **May 1** and ends on **June 30**. The Administrative Period for new employees is the two full calendar months following the end of the Initial Measurement Period.

"Break in Service" means, following an employee's termination of employment, a period of 13 or more consecutive weeks during which the employee did not have an hour of service. If the employee had not been employed for at least 13 weeks prior to his termination of employment, a Break in Service means a period of four or more consecutive weeks during which the employee did not have an hour of service, where such period is greater than the employee's period of employment.

"Full-time Employee" is an Employee who is reasonably expected to work, on average, at least 30 hours per week or 130 hours per calendar month.

"Initial Measurement Period" means the period of time during which a new employee's hours of service are measured to determine whether the employee is a Full-time Employee. The Initial Measurement Period is **12 months long**. The Initial Measurement Period starts on **the first day of the first calendar month following employee's date of hire**.

"Ongoing Employee" means an employee who has been employed by the Company for at least one complete Standard Measurement Period.

"Part-time Employee" means a new employee who the Company reasonably expects to work, on average, less than 30 hours per week during the Initial Measurement Period.

"Seasonal Employee" means an employee who is hired into a position for which the customary annual employment period is six months or less and which begins at approximately the same time of each calendar year.

"Stability Period" means the period of time during which an employee is treated as a Full-time Employee for purposes of determining eligibility for medical benefits under the Plan. The Stability Period is **12 months long.** For Ongoing Employees this period starts **July 1** and ends **June 30**.

"Standard Measurement Period" means the period during which the Company counts an employee's hours of service. The Standard Measurement Period is **12 months long**. The Standard Measurement Period starts on **May 1** and ends on **April 30**.

"Variable Hour Employee" means an employee for whom the Company cannot determine, at the employee's hire date, whether the employee is reasonably expected to work an average of at least 30 hours per week.

Eligibility

The Company offers medical benefits coverage to Full-time Employees, their dependent children and/or spouses. Dependent children and spouses are defined in the separate subsidiary Contracts for medical benefits.

Effective **October 1, 2015**, the Company will use the following Measurement Period(s) to determine whether an employee is a Full-time Employee for purposes of medical benefits coverage under the Plan:

Look-Back Measurement Period	All Employees

Look-Back Measurement Period

The Company intends to follow IRS regulations and any subsequent guidance when administering the Look-Back Measurement Period.

a) *Ongoing Employees*

For Ongoing Employees, the Company will determine whether an individual is a Full-time Employee by looking at the employee's hours of service during the Standard Measurement Period. If an Ongoing Employee is a Full-time Employee during the Standard Measurement Period, he or she will be eligible for medical benefits under the Plan during the entire Stability Period. The employee will remain eligible for medical benefits during the entire Stability Period, regardless of the employee's actual number of hours of service during the Stability Period, as long as he remains an employee of the Company. Similarly, if an employee is not a Full-time Employee during the Standard Measurement Period, he will not be eligible for medical benefits during the entire Stability Period.

b) *New Employees Expected to Work Full Time*

If the Company reasonably expects a new employee to be a Full-time Employee as of the employee's hire date, the Company will determine the employee's status as a Full-

time Employee using the employee's hours of service for each calendar month. If the employee's hours of service average at least thirty (30) hours per week or one hundred thirty (130) hours per month, the employee will be offered medical benefits coverage under the Plan pursuant to the standard eligibility and enrollment waiting periods required by the Plan, as detailed in the relevant Subsidiary Contract.

c) *New Part-time, Seasonal or Variable Hour Employees*

Newly hired Part-time, Seasonal and Variable Hour Employees must first complete an Initial Measurement Period during which they are not eligible to enroll in medical benefits under the Plan. At the end of the Initial Measurement Period, if the employee is a Full-time Employee, that employee will be eligible for medical benefits under the Plan as of completion of Measurement and Administrative Periods, and for the Stability Period.

Enrollment

The Company will use the Administrative Period to determine whether an employee is a Full-time Employee and to offer coverage to those Full-time Employees during an open enrollment period. Medical benefits coverage will be effective during the Stability Period.

Break In Service

An employee who was enrolled in medical benefits coverage under the Plan on the date of his termination of employment may resume participation in the medical benefits under the Plan on **the employee's date of rehire** if the employee has not had a Break in Service (provided that for any Look-back measurement, that the Stability period on the date of reemployment is the same as the Stability Period in effect on the date of the individual's prior termination of employment. If reemployment begins during a new Stability Period, participation in the medical benefit under the Plan will begin on this date if, based on the applicable Measurement Period, the individual is a Full-time Employee on the date of reemployment).

If the employee had not satisfied any applicable waiting period prior to his termination of employment, upon rehire, the waiting period will be reduced by the period of prior employment.

If the employee is reemployed after a Break in Service, eligibility to become a participant in the medical benefits under the Plan will be based on the individual's status on the date of rehire.

BLACKWATER COMMUNITY SCHOOL
EMPLOYEE BENEFIT PLAN
EPO PLAN OPTION
PLAN AMENDMENT #1

Blackwater Community School hereby amends the Blackwater Community School Employee Benefit Plan EPO Plan Option, hereinafter referred to as "***Plan***", as it was previously adopted on October 1, 2015. This amendment shall be effective on October 1, 2015.

WHEREAS, the provisions of the plan document provide for termination of coverage on the last day of the month in which either of the following events occur: (1) the ***employee*** ceases to meet the eligibility requirements of the ***Plan,*** and (2) the ***employee*** terminates employment with the School. It is the intent of Blackwater Community School that if the event occurs on the first day of the calendar month, termination of coverage under the ***Plan*** shall occur on the date of the event.

THEREFORE, the section entitled, *Termination of Coverage, Employee(s) Termination Date,* shall be restated as follows:

EMPLOYEE(S) TERMINATION DATE

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health plan.
2. The last day of the month in which the ***employee*** ceases to meet the eligibility requirements of the ***Plan,*** unless the loss of eligibility occurs on the first day of the calendar month. Then, coverage terminates on the first day of the calendar month.
3. The last day of the month in which employment terminates, unless termination of employment occurs on the first day of the calendar month. Then, coverage terminates on the first day of the calendar month.
4. The date the ***employee*** becomes a ***full-time,*** active member of the armed forces of any country.
5. The date the ***employee*** ceases to make any required contributions.

All remaining provisions shall prevail unless subsequently amended.

BY: Peggy Stuff DATE: April 28, 2016

BLACKWATER COMMUNITY SCHOOL
EMPLOYEE BENEFIT PLAN
PPO PLAN OPTION
PLAN AMENDMENT #1

Blackwater Community School hereby amends the Blackwater Community School Employee Benefit Plan PPO Plan Option, hereinafter referred to as "***Plan***", as it was previously adopted on October 1, 2015. This amendment shall be effective on October 1, 2015.

WHEREAS, the provisions of the plan document provide for termination of coverage on the last day of the month in which either of the following events occur: (1) the ***employee*** ceases to meet the eligibility requirements of the ***Plan,*** and (2) the ***employee*** terminates employment with the School. It is the intent of Blackwater Community School that if the event occurs on the first day of the calendar month, termination of coverage under the ***Plan*** shall occur on the date of the event.

THEREFORE, the section entitled, *Termination of Coverage, Employee(s) Termination Date,* shall be restated as follows:

EMPLOYEE(S) TERMINATION DATE

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health plan.
2. The last day of the month in which the ***employee*** ceases to meet the eligibility requirements of the ***Plan,*** unless the loss of eligibility occurs on the first day of the calendar month. Then, coverage terminates on the first day of the calendar month.
3. The last day of the month in which employment terminates, unless termination of employment occurs on the first day of the calendar month. Then, coverage terminates on the first day of the calendar month.
4. The date the ***employee*** becomes a ***full-time,*** active member of the armed forces of any country.
5. The date the ***employee*** ceases to make any required contributions.

All remaining provisions shall prevail unless subsequently amended.

BY: Peggy Stuff DATE: April 28, 2016

BLACKWATER COMMUNITY SCHOOL
EMPLOYEE BENEFIT PLAN
PPO PLAN OPTION
PLAN AMENDMENT #2

Blackwater Community School hereby amends the Blackwater Community School Employee Benefit Plan PPO Plan Option, hereinafter referred to as "***Plan***", as it was previously adopted on October 1, 2015. This amendment shall be effective on July 1, 2016.

WHEREAS, Blackwater Community School elects to include a second benefit schedule within the PPO Plan Option for eligible ***employees*** to enroll for coverage.

- The current benefit schedule shall be named the PPO High Deductible Plan.
- The second benefit schedule shall be named the PPO Low Deductible Plan.
- The PPO Low Deductible Plan option shall have a ***preferred provider*** deductible of $500 for individual, and $1,000 for family.
- The ***nonpreferred provider*** deductible shall be $1,000 for individual, and $2,000 for family.
- The ***Plan's coinsurance*** for ***preferred provider covered expenses*** shall be seventy percent (70%), and the ***nonpreferred provider Plan coinsurance*** shall be fifty percent (50%).

Therefore, within the section titled, *Schedule of Benefits, Medical Benefits,* prior to the existing benefits schedule, the following heading shall be included:

PPO High Deductible Plan

Within the section titled, *Schedule of Benefits, Medical Benefits,* the following shall be inserted after the benefits schedule for the PPO High Deductible Plan:

BENEFIT DESCRIPTION & BENEFIT LIMITATION	PREFERRED PROVIDER	NONPREFERRED PROVIDER
The ***benefit year*** is January 1st through December 31st.	After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***negotiated rate.***	After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***customary and reasonable amount.***
Precertification Penalty Failure to obtain precertification for services requiring precertification shall result in a $300 penalty deductible applying to ***covered expenses*** first, then any applicable ***benefit year*** deductible, then the ***Plan's coinsurance*** applies. No benefits payable for transplants without precertification.		
Benefit Year **Deductible** Individual (Per Person) Family (Aggregate)	$500 $1,000	$1,000 $2,000
Out-of-Pocket Expense Limit Per *Benefit Year*: (includes medical and prescription ***copays*** and ***coinsurance***) Individual Family (Aggregate) Refer to *Medical Expense Benefit, **Benefit Year** Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit.	$6,000 $12,000	$8,000 $16,000
Inpatient Hospital Precertification required.	70%	50%
Outpatient Hospital/Ambulatory Surgical Facility Specified procedures require precertification. See *Utilization Review.*	70%	50%
Ambulance Service	70% after ***PPO*** deductible	70% after ***PPO*** deductible.
Emergency Room Services	70% after ***PPO*** deductible	70% after ***PPO*** deductible
Physician's Services Home, Inpatient, Office Visit Surgery - Physician's Office Surgery - Other Pathology Anesthesiology Radiology	 70% 70% 70% 70% 70% 70%	 50% 50% 50% 50% 50% 50%
Extended Care Facility Precertification required. Limitation: 90 days ***maximum benefit*** per ***benefit year***	70%	50%
Home Health Care Precertification required.	70%	50%
Hospice Care Precertification required.	70%	50%
Durable Medical Equipment	70%	50%

BENEFIT DESCRIPTION & BENEFIT LIMITATION The ***benefit year*** is January 1st through December 31st.	PREFERRED PROVIDER After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***negotiated rate.***	NONPREFERRED PROVIDER After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***customary and reasonable amount.***

Preventive Care Services All preventive care services as recommended by the U.S. Preventive Services Task Force	100%; deductible waived	Not Covered
	For a complete listing, go to: www.healthcare.gov/coverage/preventive-care-benefits	
Pediatric Health Care	100%; deductible waived	Not Covered
	For a complete listing, go to: www.healthcare.gov/coverage/preventive-care-benefits	
Immunizations	100%. deductible waived	Not Covered
	For a complete listing, go to: www.healthcare.gov/coverage/preventive-care-benefits	
Preventive Care: Well Woman Preventive Services Includes: Well Woman Visits; Screening for gestational diabetes; Human Papillomavirus testing; counseling for sexually transmitted infections; counseling & screening for human immune-deficiency virus; contraceptive methods & counseling; breast-feeding support, supplies and counseling; screening & counseling for interpersonal & domestic violence;	100%; deductible waived	Not Covered
	For a complete listing, go to: www.healthcare.gov/coverage/preventive-care-benefits	
Routine Mammogram	100%: deductible waived	50%: deductible waived
Mental & Nervous Disorders/Chemical Dependency ***Inpatient*** Services Precertification required	70%	50%
Outpatient Services	70%	50%
Therapy Services (Radiology, Chemotherapy, Dialysis)	70%	50%
Rehabilitative Services (Physical, Speech, Occupational)	70%; deductible waived The deductible is not waived for evaluations prior to therapy.	50%; deductible waived The deductible is not waived for evaluations prior to therapy.
	Limited to 20 visits per ***benefit year*** for ***outpatient*** physical and occupational therapy combined. Limited to 20 visits per ***benefit year*** for ***outpatient*** speech therapy. Additional benefits for services of a ***preferred provider*** that exceed the annual maximum may be available if determined to be ***medically necessary*** by the ***Utilization Review Organization.*** Such benefits shall be payable at 50% up to a maximum out-of-pocket expense of $500. After the maximum out-of-pocket has been reached, benefits shall be payable at 100%.	

BENEFIT DESCRIPTION & BENEFIT LIMITATION The ***benefit year*** is January 1st through December 31st.	PREFERRED PROVIDER After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***negotiated rate.***	NONPREFERRED PROVIDER After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***customary and reasonable amount***
Chiropractic Care Limitation: 20 visits ***maximum benefit*** per ***benefit year***	70%	50%
Prosthetics	70%	50%
Dental Injury	70%	70%
Transplants **Limited to $200 per day/$10,000 while covered by this Plan for travel and lodging with no deductible or coinsurance**	70%	50%
Temporomandibular Joint Dysfunction Limited to $1,000 ***maximum benefit*** while covered by this ***Plan***.	70%	50%
Diagnostic Testing, Lab and X-ray Services	70%	50%
Neuropsychological and Cognitive Testing Limited to 10 hours of testing per calendar year	70%	50%
Cataract Surgery Limited to $500 ***maximum benefit*** for initial pair of eyeglasses or contacts following surgery	70%	50%
Hearing Services and Devices Limited to $25,000 while covered by this ***Plan.***	70%	50%
All Other Covered Expenses	70%	50%

All remaining provisions shall prevail unless subsequently amended.

BY: Peggy Schuff DATE: April 28, 2016

FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

PLAN INFORMATION SUMMARY

The Employer named below establishes a Flexible Benefits Plan (the "Plan") as set forth in this Summary Plan Description ("SPD") as of the Effective Date set forth below. The purpose of the Plan is to provide eligible Employees a choice between cash and the specified welfare benefits described in this Plan Information Summary (see "Benefits Provided Under the Plan"). Pre-tax Contribution elections under the Plan are intended to qualify for the exclusion from income provided in Section 125 of the Internal Revenue Code of 1986.

FLEXIBLE BENEFITS PLAN EMPLOYER INFORMATION

1) Name and Address of Employer: **BLACKWATER COMMUNITY SCHOOL**

   Plan Administrator: **PEGGY HUFF**
   3652 E BLACKWATER SCHOOL RD
   COOLIDGE, AZ 85128-6609

The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact and to construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD.

2) Employer's Telephone Number: **(520) 215-5859**
3) Employer's Federal Tax Identification Number: **86-0797149**
4) Plan Number Assigned to Cafeteria Plan (e.g., 501 if this is the first ERISA Plan Number assigned): **501 (Wrap Plan) and 502 (AFLAC)**
5) 125 Start Date: **10/01/15**
6) Effective Date of this Plan: **10/01/15**
7) Last Day of the Plan Year: **06/30/16**
   Subsequent Plan Years: **07/01-06/30**
8) Name and Address of FSA Claim Administrator: **SAME**
9) Name and Address of registered agent for service of legal process: **PEGGY HUFF**

10) Affiliated Employers that will participate in the Plan (affiliates in excess of 30 are listed in Appendix 1):

11) Employer's Type of Business: **OTHER**

ELIGIBILITY

All Employees employed by the Employer shall be eligible to participate under the Plan except the following:

An eligible Employee may become a Participant in the Plan:

[ ] Immediately, upon the first day of employment (but not prior to the Effective Date of the Plan).

[ ] On the **day** following commencement of employment.

[X] **On the first day of the month following 60 days of employment.**

[ ] Other: **OTHER**
provided the Employee completes a Premium Deduction Authorization ("PDA"). However, eligibility for coverage under any given Benefit Plan or Policy shall be determined by the terms of that Benefit Plan of Policy, and reductions of the Employee's Compensation to pay Pre-tax or After-tax Contributions shall commence when the Employee becomes covered under the applicable Benefit Plan or Policy.

An eligible Employee may become a Participant in the Dependent Care and/or Medical Expense Reimbursement Plan(s) (if elected below):

[ ] On the same day such Employee is eligible for the Pre-Tax Contribution benefits under the Plan.

[ ] On the day following commencement of employment.

[ ] On the first day of the month following days of employment.

[ ] Other: **OTHER**, provided the Employee completes a PDA selecting such benefits.

BENEFITS PROVIDED UNDER THE PLAN

The following Benefit Plans and Policies subject to the terms and conditions of the Plan are available for election by eligible Employees. The maximum a Participant can contribute via the PDA is the maximum aggregate cost of the Benefit Plans or Policies elected minus any Nonelective Contribution made by the Employer. It is intended that such Pre-tax Contribution amounts shall, for tax purposes, constitute an Employer contribution, but may constitute Employee contributions for state insurance law purposes. Copies of the Benefit Plans or Policies (or a list of eligible Policy numbers) shall be attached as an appendix to this Plan.

[X] Group Major Medical Coverage

[X] Vision Care Coverage

[ ] Disability Income - Short Term (A&S)

[X] Cancer Insurance

[X] Dental Coverage

[ ] Group Term Life Insurance

[ ] Disability Income - Long Term (LTD)

[ ] Intensive Care Insurance

[X] Accident Insurance

[ ] Hospital Indemnity Insurance (HIP)

[X] Specified Health Event

[ ] Personal Sickness Indemnity (PSI)

[ ] Medical Care Expense Reimbursement described in Appendix I to this SPD, not to exceed $ **0** per Plan Year pursuant to the **BLACKWATER COMMUNITY SCHOOL** Medical Care Expense Reimbursement Plan.

Name and Address of Medical Care Expense Reimbursement Plan
COBRA Administrator (if applicable): _____
_____
_____

[ ] Dependent Care Expense Reimbursement described in Appendix I to this SPD.

[ ] Health Savings Account (as defined in Code Section 223) established with the following

Custodian/Trustee: _____

[ ] Opt-out Option: See Employer enrollment material.

THE FUNDING AGENT

The Employer selects the following Funding Agent for the Plan (check one):

❑ The Employer, which will comply with the requirements of Article VII of the Plan.

❑ The Flexible Benefits Trust created concurrently with the execution of the Plan, which shall receive contributions under the Plan in accordance with Article VII of the Plan.

ADMINISTRATIVE EXPENSES

Administrative Expenses incurred in operating the Plan shall be paid by (check one):

❑ The Employer, except as otherwise noted in the Plan.

❑ The Participants, except as otherwise noted in the Plan.

FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

Introduction

Your employer (the "Employer") is pleased to sponsor an employee benefit program known as a "Flexible Benefits Plan" (the "Plan") for you and your fellow employees. Under federal tax laws, it is also known as a "cafeteria plan". It is so called because it lets you choose from several different insurance and fringe benefit programs according to your individual needs. The Employer provides you with the opportunity to use pre-tax dollars to pay for them by entering into a salary redirection arrangement instead of receiving a corresponding amount of your regular pay. This arrangement helps you because the benefits you elect are nontaxable; you save Social Security and income taxes on the amount of your salary redirection. Alternatively, your Employer may allow you to pay for any of the available benefits with after-tax contributions on a salary deduction basis.

This Summary Plan Description ("SPD") describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. Information relating to the Plan that is specific to your Employer is described in the Plan Information Summary attached to the front of this SPD. You will be referred to the Plan Information Summary throughout the SPD. The Plan is also established pursuant to a plan document into which this SPD has been incorporated. If there is a conflict between the official plan document and the SPD, the plan document will govern.

In some cases, the Employer may adopt a Medical Care and/or Dependent Care Reimbursement Plan. If so, they will be listed in the Plan Information Summary as "Benefits Provided under the Plan," and the SPD for each Reimbursement Plan adopted by the Employer will be set forth in Appendix I to this SPD. To the extent that the Employer adopts a Medical Care Reimbursement Plan as indicated in the Plan Information Summary, a summary of your rights and obligations under HIPAA's privacy rules is attached to this SPD as Appendix II.

You may also be able to make pre-tax contributions to a Health Savings Account (as defined in Code Section 223) through this Plan if Health Savings Accounts are identified as an included benefit under "Benefits Provided under the Plan" in the Plan Information Summary. If Health Savings Accounts are identified as a benefit plan option offered under the Plan, your rights and obligations in regard to such contributions will be set forth in the Health Savings Account Contribution Appendix attached hereto.

Questions & Answers about the Flexible Benefits Plan

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to allow eligible employees to pay for certain benefits offered under the Plan (called "Benefit Plans or Policies") with pre-tax dollars called "Pre-tax Contributions". Pre-tax Contributions are described in more detail in Q-8 of this SPD.

Q-2. What benefits can I purchase on a pre-tax basis through the Plan?

You will be able to choose to participate in the Plan's various pre-tax options by filling out any required enrollment form(s) for the component Benefit Plans or Policies offered under the Plan. The complete list of Benefit Plans or Policies offered under the Plan is located in the Plan Information Summary under "Benefits Offered Under the Plan." NOTE: You may only contribute with Pre-tax Contributions towards the cost of Benefit Plans or Policies that cover you, your legal Spouse, and/or your tax Dependents defined under Internal Revenue Code Section 152. Each Benefit Plan or Policy may define eligible Dependents more narrowly for purposes of coverage under the particular Benefit Plan or Policy.

Q-3. Who can participate in the Plan?

Each employee of the Employer (or an Affiliated Employer identified in the Plan Information Summary) who satisfies the eligibility requirements described in the Plan Information Summary and who is eligible to participate in any of the Benefit Plans or Policies offered under the Plan will be eligible to participate in this Plan as of the date described in the Plan Information Summary (see Q-5 of this SPD for instructions on how to become a Participant). Those employees who actually participate in the Plan are called "Participants." The terms of eligibility of this Plan do not override the terms of eligibility of each of the Benefit Plans or Policies offered under the Plan. For the details regarding eligibility provisions, benefit amounts, and premium schedules for each of the Benefit Plans or Policies, please refer to the plan summary for each of the Benefit Plans or Policies listed in the Plan Information Summary.

Only coverage for an Employee and the Employee's Dependents may be paid for under this Plan. A dependent is defined generally as an individual who would be considered the Employee's spouse under the federal income tax code or the Employee's tax dependents as defined in Code Section 152; however, for purposes of health benefits and Dependent Care Reimbursement ("DDC") benefits offered under the Plan, a dependent is defined as (i) for health plan purposes, as set forth in Code Section 105(b) and (ii) for DDC purposes, as any person who meets the requirements to be a "qualifying individual" as defined in the DDC component SPD.

Q-4. When does my participation in the Plan end?

You continue to participate in the Plan until (i) you elect not to participate in accordance with Q-9 of this SPD; (ii) you no longer satisfy the eligibility requirements described in the Plan Information Summary; (iii) you terminate employment with the Employer; or (iv) the Plan is terminated or amended to exclude you or the class of employees of which you are a member. If your employment with the Employer is terminated during the Plan Year or you otherwise cease to be eligible, your active participation in the Plan will **automatically** cease, and you will not be able to make any more

Pre-tax Contributions under the Plan. If you are rehired within the same Plan Year or you become eligible again, you may make new elections, provided that you are rehired or become eligible again more than 30 days after you terminated employment or lost eligibility. If you are rehired or again become eligible within 30 days or less, your prior elections will be reinstated and remain in effect for the remainder of the Plan Year unless you again lose eligibility.

Q-5. How do I become a Participant?

You become a Participant by communicating to your employer, prior to the Plan start date, your election to participate in the Plan by signing an individual Premium Deduction authorization (PDA) on which you elect one or more of the Benefit Plans or Policies available under the Plan, as well as agree to a salary redirection to pay for those benefits so elected. You will be provided a PDA when you first become eligible to participate in this Plan.

Q-6. What are the enrollment periods for entering the Plan?

If you are eligible on the effective date of the Plan, you must enroll during the enrollment period immediately preceding the effective date of the Plan. Otherwise, you must enroll during either the "Initial Enrollment Period" or the "Annual Enrollment Period". You will be notified of the dates that each enrollment period begins and ends in the enrollment material provided to you prior to each enrollment period. If you make an election during the Initial Enrollment Period, your participation in this Plan will begin on the later of your eligibility date described in the Plan Information Summary, the first pay period coinciding with or next following the date that your election is received by the Plan Administrator (or its designated claims administrator) or the date coverage under a Benefit Plan or policy that you elect begins. The effective date of coverage under the applicable Benefit Plan(s) or Policy(ies) is governed by the terms of each Benefit Plan or Policy, as set forth in the governing documents for each Benefit Plan or Policy. The election that you make during the Initial Enrollment Period is effective for the remainder of the Plan Year and generally cannot be revoked during the Plan Year unless you have a Change in Status event as described in Q-9 below. If you do not make an election during the Initial Enrollment Period, you will be deemed to have elected not to participate in this Plan for the remainder of the Plan Year. You may, however, be covered by certain Benefit Plans or Policies automatically (and be required to contribute with pre-tax dollars) even if you fail to make an election. These automatic Benefit Plans or Policies are called "Default Benefits" and will be identified in the enrollment material that you receive.

The election that you make during the Annual Enrollment Period is effective the first day of the next Plan Year and is irrevocable for the entire Plan Year unless you have a Change in Status event described in Q-9 below. A Participant who fails to complete, sign, and file a PDA during the Annual Enrollment Period as required shall be deemed to have elected to continue participation in the Plan with the same benefit elections as during the prior Plan Year (adjusted to reflect any increase/decrease in applicable premiums), and except for a Change in Status, will not be permitted to modify his election until the next Annual Enrollment Period. Notwithstanding the foregoing, annual elections for participation in the Medical Care and Dependent Care Expense Reimbursement Plans, if offered under the Plan, must be made by submitting a PDA prior to the beginning of each Plan Year -- no deemed elections shall occur with respect to such benefits.

The Plan Year is generally a 12-month period (except during the initial or last Plan Year of the Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Summary.

Q-7. What tax advantages are available through the Plan?

Suppose your monthly gross pay is $2,500 per month and your cost for coverage is $140 per month. Also, suppose your total withholdings (income tax and Social Security) are 22.65%. After paying for coverage from your after-tax pay, your take home pay is $1,794. However, under the pre-tax premium plan, you will be considered to have received $2,360 gross pay rather than $2,500 for tax purposes with $140 contributed for medical coverage. This means your take home pay will be $1,825 with the pre-tax premium plan rather than $1,794 without it. Thus, you save $31 per month ($372 per year) by participating in the pre-tax premium plan. The Table below illustrates this savings.

	With Cafeteria Plan	Without Cafeteria Plan
Gross Monthly Pay	$2,500	$2,500
Pre-Tax Coverage Under Plan	140	--
Taxable Income	2,360	2,500
Estimated Federal Tax (15%)	354	375
FICA Tax	181	191
After-tax Coverage	--	140
Take Home Pay	1,825	1,794

Potential Monthly Savings: $31.00

Q-8. How are my contributions under the Benefit Plans or Policies made?

When you become a Participant, your share of the contributions for the elected Benefit Plan or Policy(ies) will be paid with Pre-tax Contributions elected on the PDA. Pre-tax Contributions are amounts withheld from your gross income before any applicable federal and state taxes have been deducted (some state tax laws do not recognize Pre-tax Contributions). In addition, all or a portion of the cost of the Benefit Plans or Policies may, in the Employer's discretion, be paid with contributions made by the Employer on behalf of each Participant (these are called "Nonelective Contributions"). The amount of Nonelective Contribution that is applied towards the cost of the Benefit Plan(s) or

Policy(ies) for each Participant and/or level of coverage is subject to the sole discretion of the Employer, and it may be adjusted upward or downward in the Employer's sole discretion. The Nonelective Contribution amount will be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon your Dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the Employer deems relevant. In no event will any Nonelective Contribution be disbursed to you in the form of additional, taxable Compensation except as otherwise provided in the enrollment material. To the extent set forth in the enrollment material, the Employer may make available a certain amount of Nonelective Contributions and then allow you to allocate the Nonelective Contributions among the various Benefit Plan(s) or Policy(ies) that you choose (subject to restrictions described in the enrollment material).

Q-9. Can I ever change my election during the Plan Year?

Generally, you cannot change your election to participate in the Plan or vary the Pre-tax Contribution amounts although your election will terminate if you are no longer working for the Employer or no longer eligible under the terms of the Plan. Otherwise, you may change your elections for Pre-Tax Contributions only during the Annual Enrollment Period, and then, only for the coming Plan Year. There are several important exceptions to this general rule: You may change or revoke your previous election during the Plan Year if you file a written request for change with the Plan Administrator (or its designated claims administrator) within 30 days of any of the following events:

1. **Change in Status**. If one or more of the following "Changes in Status" occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator determines are permitted under subsequent IRS regulations:

   - a change in your legal marital status (such as marriage, legal separation, annulment, or divorce or death of your Spouse);
   - a change in the number of your tax Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);
   - any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a cafeteria plan (including this Plan and the Plan of another employer) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit (NOTE: The specific rules governing election changes when you take a leave of absence are described in Q-13 of this SPD);
   - an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, getting married, or ceasing to be a student);
   - a change in your, your Spouse's or your Dependent's place of residence.
   - a change in your employment status such that you are no longer to average 30 hours or more per week each month but does not otherwise cause you to lose eligibility for group health benefits that provide minimum essential coverage; or
   - you are eligible to enroll in a Qualified Health Plan offered in the Marketplace during the Marketplace's special or annual enrollment period.

   If a Change in Status occurs and you want to make a corresponding election change, you must inform the Plan Administrator and complete a new election within 30 days from the date of the event. The election change must be on account of and correspond with the Change in Status event as determined by the Plan Administrator with the exception of special enrollment resulting from birth, placement for adoption or adoption, all election changes are prospective.

   As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects eligibility for coverage. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of Dependents who may benefit under the plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

   - *Loss of Dependent Eligibility.* For accident and health benefits (e.g., health, dental and vision coverage, and Medical Care Reimbursement Plan), a special rule governs which types of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-Dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-Dependent coverage would be consistent with this Change in Status. However, there are instances in which you may be able to increase your Pre-tax Contributions to pay for COBRA coverage of a Dependent child or yourself.

- *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's cafeteria plan (or Benefit Plan or Policy) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.

- *Dependent Care Reimbursement Plan Benefits (if offered under the Plan. See the list of Benefit Plans or Policies offered under the Plan in the Plan Information Summary).* With respect to the Dependent Care Reimbursement Plan benefit (if offered by the Plan), you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of Dependent care assistance expenses for the available tax exclusion.

  Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a Dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund Dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the Dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the Dependent care program would be consistent with this Change in Status.

- *Ability to Procure Minimum Essential Coverage.* For a Change in Status in which you no longer average 30 hours or more per week each month but do not otherwise lose eligibility for group health benefits that provide minimum essential coverage, your election to revoke coverage under the Plan would correspond with that Change in Status only if you certify your intent to enroll yourself and any other dependents whose coverage is revoked in another plan that provides minimum essential coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

- *Gain of Coverage Eligibility in the Marketplace.* For a Change in Status in which you gain eligibility for coverage in a Qualified Health Plan in the Marketplace's special or annual enrollment period, your election to revoke coverage under the Plan would correspond with that Change in Status only if you certify your intent to enroll yourself and any other dependents whose coverage is revoked in new coverage under a Qualified Health Plan that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

- *Group Term Life Insurance, Disability Income, or Dismemberment Benefits (if offered under the Plan. See the list of Benefit Plans or Policies offered under the Plan in the Plan Information Summary).* For group term life insurance, disability income, and accidental death and dismemberment benefits, if you experience any Change in Status (as described above), you may elect either to increase or decrease coverage.

  Example: Employee Mike is married to Sharon, and they have one child. The employer's plan offers a cafeteria plan which funds group-term life insurance coverage (and other benefits) through salary reduction. Before the plan year Mike elects $10,000 of group-term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his group-term life insurance coverage would each be consistent with this Change in Status.

2. **Special Enrollment Rights.** If you, your Spouse, and/or a Dependent are entitled to special enrollment rights under a Benefit Plan or Policy that is a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage. Furthermore, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired Dependents, provided that you request enrollment within the Election Change Period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days. Please refer to the group health plan description for an explanation of special enrollment rights.

3. **Certain Judgments, Decrees and Orders**. If a judgment, decree or order from a divorce, separation, annulment, or custody change requires your Dependent child (including a foster child who is your tax Dependent) to be covered under

this Plan, you may change your election to provide coverage for the Dependent child identified in the order. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

4. **Entitlement to Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.

5. **Change in Cost**. If you are notified that the cost of your Benefit Plan or Policy coverage under the Plan *significantly* increases or decreases during the Plan Year, you may make certain election changes. If the cost significantly increases, you may choose either to make an increase in your contributions, revoke your election and receive coverage under another Benefit Plan or Policy that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the option that decreased in cost. For *insignificant* increases or decreases in the cost of Benefit Plans or Policies, however, your Pre-tax Contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met.

   Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

6. **Change in Coverage**. If you are notified that your Benefit Plan or Policy coverage under the Plan is significantly curtailed, you may revoke your election and elect coverage under another Benefit Plan or Policy that provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, you may revoke your election and elect to receive on a prospective basis coverage provided by the newly added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Plan Year for this Plan is different from the Plan Year of the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your Spouse, or your Dependent if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator will have final discretion to determine whether the requirements of this section are met.

   Additionally, your election(s), may be modified downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Q-10. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-11. What happens if my claim for benefits under this Plan is denied?

This SPD describes the basic features of the Plan. If your claim is for a benefit under one of the component Benefit Plans or Policies, you will generally proceed under the claims procedures applicable under the component Benefit Plan or Policy (see the plan summary for each of the Benefit Plans or Policies that you elect). However, if you are denied a benefit under this Plan, the claims procedure under this Plan will apply. You will be notified if your claim under the Plan is denied. The notice of denial will be furnished to you within 30 days after receiving your claim. However, if additional time is needed to process your claim you will be notified before the initial 30-day period has expired. The notice will explain why an extension is necessary and the date a decision is expected to be rendered. In no event will an extension go beyond 15 days after the end of the initial 30-day period. The notice of the denial will include the specific reasons for the denial and the relevant plan provisions on which the denial was based.

If your claim is denied in whole or in part, you may appeal by requesting a review of the denied claim, as set forth in the notice of denial, within 180 days after you receive notice of the denial. If there are two levels of appeal (as indicated in the notice of denial), you will have a reasonable amount of time in which to request a second review and such time period will be identified in the notice of denial. As part of the appeal process (whether there is one or two appeals), you or your authorized representative may examine documents, records, and other information relevant to your claim and submit issues, documents and comments in writing. Within 60 days after the request for review is received, you will be notified in writing of the decision on review.

The notice of denial will indicate whether there are one or two levels of appeals and will contain the same type of information provided to you in the first notice of denial. If there are two levels of Plan appeals, the decisions on appeal will be made within 30 days after the request for each review is received. The Plan Administrator is the claims fiduciary for making the final decision under the plan.

In the event of your death, your beneficiary has the same rights and is subject to the same time limits and other restrictions that would otherwise apply to you under the claims procedures explained above.

Q-12. What effect will Plan participation have on Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

Q-13. What happens if I take a leave of absence?

(a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your Benefit Plans or Policies providing health coverage on the same terms and conditions as though you were still active (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).

(b) Your Employer may elect to continue all coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-tax Contributions if that is what was used before the FMLA leave began).

(c) In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution with after-tax dollars while on leave, or you may be given the option to pre-pay all or a portion of your share of the contribution for the expected duration of the leave with Pre-tax Contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you provided, however, that pre-payments of Pre-tax Contributions may not be utilized to fund coverage during the next Plan Year, or by other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave). The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA and the Employer's internal policies and procedures regarding leaves of absence. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator.

(d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan upon return from such leave on the same basis as you were participating in the Plan prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Plans or Policies providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.

(e) The Employer may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and Employer.

(f) If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Plans or Policies providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Plans or Policies are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.

(g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Plan or Policy offered under this plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Plan or Policy, the election change rules in Q-9 of this SPD will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

Q-14. Is there any other information that I should know about the Plan?

Participation in the Plan does not give any Participant the right to be retained in the employ of his or her Employer or any other right not specified in the Plan. The Plan Administrator's name, address and telephone number appear in the Plan Information Summary attached to the front of this SPD. The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD. Other important information such as the Plan Number and Plan Sponsor's name and address has also been provided in the Plan Information Summary.

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FLEXIBLE BENEFITS PLAN

PREAMBLE

The Employer hereby establishes a Flexible Benefits Plan ("Plan") for its Employees for purposes of providing eligible Employees with the opportunity to choose from among the fringe benefits available under the Plan. The Plan is intended to qualify as a cafeteria plan under the provisions of Code Section 125. The Dependent Care Expense Reimbursement Plan ("DDC") is intended to qualify as a Code Section 129 dependent care assistance plan, and the Medical Care Expense Reimbursement Plan ("URM") is intended to qualify as a Code Section 105 medical expense reimbursement plan. Although printed within this document, the DDC and URM Plans are separate written plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Sections 105 and 129 of the Code and all applicable provisions of ERISA. The DDC and the URM are available only if designated as a Benefit Plan or Policy in the Summary Plan Description (SPD).

FLEXIBLE BENEFITS PLAN

ARTICLE I - DEFINITIONS

1.01 **"Affiliated Employer"** means any entity who is considered with the Employer to be a single employer in accordance with Code Section 414(b), (c), or (m) of the Code.

1.02 **"After-tax Contribution(s)"** means amounts withheld from an Employee's Compensation pursuant to a Premium Deduction Authorization (PDA) after all applicable state and federal taxes have been deducted. Such amounts are withheld for purposes of purchasing one or more of the Benefit Plans or Policies available under the Plan.

1.03 **"Anniversary Date"** means the first day of any Plan Year.

1.04 **"Benefit Plan(s) or Policy(ies)"** means those Qualified Benefits available to a Participant under this Plan as set forth in the SPD, as amended and/or restated from time to time.

1.05 **"Board of Directors"** means the Board of Directors or other governing body of the Employer (the "Board"). The Board, upon adoption of this Plan, appoints the Plan Administrator to act on the Employer's behalf in all matters regarding the Plan.

1.06 **"Change in Status"** means any of the events described in the SPD, as well as any other events included under subsequent changes to Code Section 125 or regulations issued under Code Section 125, that the Plan Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis as a reason to change the election mid-year. Note: See the SPD for requirements that must be met to permit certain mid-year election changes on account of a Change in Status.

1.07 **"Code"** means the Internal Revenue Code of 1986, as amended.

1.08 **"Compensation"** means the cash wages or salary paid to an Employee by the Employer.

1.09 **"Dependent"** means any individual who is a tax dependent of the Participant as defined generally in Code Section 152(a) except as otherwise set forth in Code Section 21 (for Dependent Care FSA purposes, if offered under the Plan), Code Section 105 (for health plan purposes, if offered under the Plan), and Code Section 223 (for Health Savings Account purposes, if offered under the Plan). Also, for DDC purposes, a Dependent shall also be defined as in Code section 21(e)(5) (i.e., dependent of the custodial parent as defined in Code Section 152(e)). Children, as defined in Code Section 152(f)(1), are considered Dependents until age 26 (regardless of residence, marital status, tax dependent status, student status, or other factors).

1.10 **"Dependent Care Reimbursement"** shall have the meaning assigned to it by Section 5.01 of the Plan.

1.11 **"Earned Income"** means all income derived from wages, salaries, tips, self-employment, and other Compensation (such as disability or wage continuation benefits), but only if such amounts are includable in gross income for the taxable year. Earned income does not include any other amounts excluded from earned income under Code § 32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

1.12 **"Effective Date"** of this Plan is the effective date set forth in the SPD.

1.13 **"Eligible Employment-Related Expenses"** means those Qualifying Employment-Related Expenses (as defined below) paid or incurred incident to maintaining employment after the date of the Employee's participation in the DDC and during the Plan Year (plus any applicable grace period extension as described in the SPD), other than amounts paid to:

(a) an individual with respect to whom a Dependent deduction is allowable under Code Sec. 151(c) to the Participant or his Spouse;

(b) the Participant's Spouse; or

(c) a child of the Participant who is under 19 years of age at the end of the taxable year in which the expenses were incurred

1.14 **"Eligible Medical Expenses"** means those expenses incurred by the Employee, or the Employee's Spouse or Dependents, after the date of the Employee's participation in the URM and during the Plan Year (plus any applicable grace period extension or carryover option as described in the SPD) to the extent that the expense satisfies the conditions set forth in the Summary Plan Description and are for "medical care" as defined by Code Section 213(d). For purposes of this Plan, the following expenses are not considered "Eligible Medical Expenses" even if they otherwise constitute "medical care" under Code Section 213(d): i) expenses for qualified long term care services (as defined in Code § 7702B(c)); and ii) expenses incurred for health insurance premiums; and iii) over-the-counter drugs and medicines that are not prescribed by a physician. For purposes of this Plan, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense, regardless of when the expense is paid.

1.15 **"Employee"** means any individual who is considered to be in a legal employer-employee relationship with the Employer for federal tax-withholding purposes. Such term includes "former employees" for the limited purpose of allowing continued eligibility for benefits hereunder for the remainder of the Plan Year in which an employee ceases to be employed by the Employer. The term "Employee" shall not include any leased employee (as that term is defined in Code Section 414(n)) or any self- employed individual who receives from the Employer "net earnings from self-employment" within the meaning of Code Section 401(c)(2) unless such individual is also an Employee.

1.16 **"Employer"** means the Employer and the Affiliated Employers named in the SPD provided, however, that when the Plan provides that the Employer has a certain power (e.g., the appointment of a Plan Administrator, entering into a contract with a third party insurer, or amendment or termination of the plan) the term "Employer" shall mean only that entity named on the first line of the Plan Information Summary of the SPD, and not any Affiliated Employer. Affiliated Employers who sign the Plan Information Summary and/or otherwise adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein.

1.17 **"ERISA"** shall mean the Employee Retirement Income Security Act of 1974, as amended.

1.18 **"Health Care Reimbursement"** shall have the meaning assigned to it by Section 5.01 of the Plan.

1.19 **"Highly Compensated Individual"** means an individual defined under Code Section 125(e) or 414(q), as amended, as a "highly compensated individual" or a "highly compensated employee."

1.20 **"Key Employee"** means an individual who is a "key employee" as defined in Code Section 125(b)(2), as amended.

1.21 **"Nonelective Contribution(s)"** means any amount that the Employer, in its sole discretion, may contribute on behalf of each Participant to provide benefits for such Participant and his or her Spouse and Dependents, if applicable, under one or more of the Benefit Plan(s) or Policy(ies) offered under the Plan. The amount of employer contribution that is applied towards the cost of the Benefit Plan(s) or Policy(ies) for each Participant and/or level of coverage shall be subject to the sole discretion of the Employer. The amount of Nonelective Contribution for each Participant may be adjusted upward or downward in the contributing Employer's sole discretion. The amount shall be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon the Participant's dependent status, commencement or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer shall prescribe. To the extent set forth in the SPD or enrollment material, the Employer may make Nonelective Contributions available to Participants and allow Participants to allocate the Nonelective Contributions among the various Benefit Plans or Policies offered under the Plan in a manner set forth in the SPD of additional, taxable Compensation except as otherwise provided in the SPD or enrollment material.

1.22 **"Participant"** means an Employee who becomes a Participant pursuant to Article II.

1.23 **"Plan"** means the Flexible Benefits Plan, the SPD (defined in Section 1.35 herein) and (if applicable) the related Trust created by this document.

1.24 **"Plan Administrator"** means the person(s) or Committee identified in the SPD that is appointed by the Employer with authority, discretion, and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator shall be the Employer.

1.25 **"Plan Year"** shall be the period of coverage set forth in the SPD (as extended by any applicable grace period as set forth in the SPD).

1.26 **"Premium Deduction Authorization" or "PDA"** Means the actual or deemed agreement pursuant to which an eligible Employee or Participant elects to contribute his share of the cost of chosen Benefit Plans or Policies with Pre-tax or

After-tax contributions and/or Benefit Credits (if offered under the plan) in accordance with Article III herein. If the Employer utilizes an interactive voice response (IVR) system or web-based program for enrollment, the PDA may be maintained on an electronic database in accordance with all applicable federal and/or state laws.

1.27 **"Pre-tax Contribution(s)"** means amounts withheld from an Employee's Compensation pursuant to a Premium Deduction Authorization before any applicable state and federal taxes have been deducted. The amounts are withheld for purposes of purchasing one or more of the Benefit Plans or Policies available under the Plan. This amount shall not exceed the premiums or contributions attributable to the most costly Benefit Plan or Policy afforded hereunder, and for purposes of Code Section 125, shall be treated as an Employer contribution (this amount may, however, be treated as an Employee contribution for purposes of state insurance laws).

1.28 **"Qualified Benefit"** means any benefit excluded from the Employee's taxable income under Chapter 1 of the Code other than Sections 106(b), 117, 124, 127, or 132 and any other benefit permitted by the Income Tax Regulations (i.e., any life insurance coverage that is includable in gross income by virtue of exceeding the dollar limitation on nontaxable coverage under Code Sec. 79). Notwithstanding the previous sentence, benefits prohibited under Section 125(f) (e.g. qualified health plans (as defined in Section 1301 of the Affordable CareAct) that are purchased in the individual market through a public Exchange and long-term care insurance) are not "Qualified Benefits".

1.29 **"Qualifying Employment-Related Expenses"** means those expenses that would be considered to be employment-related expenses under Section 21(b)(2) of the Code (relating to expenses for household and dependent care services necessary for gainful employment) if paid for by the Employee to provide Qualifying Services.

1.30 **"Qualifying Individual"** means an individual defined as a "Qualifying Individual" in the Summary Plan Description.

1.31 **"Qualifying Services"** means services relating to the care of a Qualifying Individual that enable the Participant or his Spouse to remain gainfully employed which are performed:

(a) in the Participant's home; or

(b) outside the Participant's home for (1) the care of a Dependent of the Participant who is under age 13, or (2) the care of any other Qualifying Individual who resides at least eight (8) hours per day in the Participant's household. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six (6) individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.

1.32 **"Reimbursement Account(s)" or "Account(s)"** shall be the funding mechanism by which amounts are withheld from an Employee's Compensation and retained for future Health Care Reimbursement (as defined in Section 1.18 herein) and Dependent Care Reimbursement (as defined in Section 1.10 herein) to the extent adopted by the Employer as set forth in the SPD. No money shall actually be allocated to any individual Participant Account(s); any such Account(s) shall be of a memorandum nature, maintained by the Administrator for accounting purposes, and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the Participant Account(s).

1.33 **"Spouse"** means an individual who is legally married to a Participant (and who is treated as a spouse under the Code), but for purposes of the Dependent Care Reimbursement Plan provisions, shall not include an individual who, although married to the Participant, files a separate federal income tax return, maintains a separate, principal residence from the Participant during the last six months of the taxable year, and does not furnish more than one-half of the cost of maintaining the principal place of abode of the Qualifying Individual.

1.34 **"Student"** means an individual who, during each of five (5) or more calendar months during the Plan Year, is a full time student at any college or university, the primary function of which is the conduct of formal instruction, and which routinely maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly presented.

1.35 **"Summary Plan Description" or "SPD"** means the document attached as Attachment I to the Plan document that describes the term of Plan not set forth herein. The SPD and all applicable appendices are incorporated hereto by reference.

1.36 **"Trustee"** (if applicable) means the person(s) or institution (and their successors) named on the signature page attached hereto, who have assented to being so named by their signature to this Agreement, otherwise empowered to hold and disburse the funds that are created hereunder.

ARTICLE II - ELIGIBILITY AND PARTICIPATION

2.01 **Eligibility to Participate.** Each Employee who satisfies the eligibility requirements set forth in the SPD shall be eligible to participate in this Plan as of any applicable entry date set forth in the SPD. The provisions of this Article are not

intended to override any eligibility requirement(s) or waiting period(s) specified in the applicable Benefit Plans or Policies and the terms of eligibility and participation for the Benefit Plan(s) or Policy(ies) offered under the Plan shall be subject to the requirements specified in the governing documents of the Benefit Plans or Policies.

2.02 **Termination of Participation**. Participation shall terminate on the earliest of the dates set forth in the SPD.

2.03 **Eligibility to Participate in Reimbursement Accounts.** Each Employee who satisfies the eligibility requirements set forth in the SPD shall be eligible to participate in the Reimbursement Accounts, if adopted by the Employer, on the date set forth in the SPD. Participation in the Reimbursement Accounts shall be effective on the date set forth in the SPD.

2.04 **Qualifying Leave Under FMLA.** Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993 (the "FMLA"), then to the extent required by the FMLA, the Participant will be entitled to continue the Participant's Benefit Plans or Policies that provide health coverage (including URM benefits to the extent offered under the Plan) on the same terms and conditions as if the Participant were still an active Employee. The requirements for continuing coverage, procedures for FMLA leave, and payment option(s) provided by the Employer (as described above) will be set forth in the SPD and will be administered in accordance with the regulations issued under Code Section 125 and in accordance with the FMLA.

2.05 **Non-FMLA Leave.** If a Participant goes on an unpaid leave of absence that does not affect eligibility under this Plan or the Benefit Plans or Policies chosen by the Participant, then the Participant will continue to participate and the contributions due for the Participant will be paid by one or more of the payment options described in the SPD. If a Participant goes on an unpaid leave that affects eligibility under this Plan or the Benefit Plans or Policies chosen by the Participant, the election change rules in Section 3.04 will apply. If such policy requires coverage to continue during the leave but permits a Participant to discontinue contributions while on leave, the Participant will, upon returning from leave, be required to repay the contributions not paid by the Participant during the leave.

ARTICLE III - BENEFIT ELECTIONS

3.01 **Election of Contributions**. A Participant may elect any combination of Pre-tax Contributions or After-tax Contributions (as set forth in the SPD) to fund any Benefit Plan or Policy available under the Plan, provided that only Qualified Benefits may be funded with Pre-tax Contributions. The Employer may, but is not required, to allocate Non-elective Contributions to one or more Benefit Plans or Policies offered under the Plan and to the extent set forth in the SPD or enrollment material, may allow the Participants to allocate his allotted share of Nonelective Contributions among the various Benefit Plans or Policies in a manner set forth in the SPD or enrollment material.

3.02 **Initial Election Period.**

(a) **Currently Eligible Employees.** An Employee who is eligible to become a Participant in this Plan as of the Effective Date should complete, sign and file a PDA with the Plan Administrator during the election period (as specified by the Plan Administrator) immediately preceding the Effective Date of the Plan in order to become a Participant on the Effective Date. The elections made by the Participant on this initial PDA shall be effective, subject to Section 3.04, for the Plan Year beginning on the Effective Date.

(b) **New Employees and Employees Who Have Not Yet Satisfied The Plan's Waiting Period**. An Employee who becomes eligible to become a Participant in this Plan after the Effective Date should complete, sign and file a PDA with the Plan Administrator (or its designated third party administrator as set forth on the PDA) during the Initial Election Period set forth in the SPD or the enrollment material. Participation will commence under this Plan as set forth in the SPD. Coverage under the component Benefit Plans or Policies will be effective in accordance with the governing provisions of such Benefit Plans or Policies.

(c) **Failure to Elect.** An eligible Employee who fails to complete, sign and file a PDA in accordance with paragraph (a) or (b) above during an initial election period may become a Participant on a later date in accordance with Section 3.03 or 3.04.

3.03 **Annual Election Period.** Each Employee who is a Participant in this Plan or who is eligible to become a Participant in this Plan shall be notified, prior to each Anniversary Date of this Plan, of his right to become a Participant in this Plan, to continue participation in this Plan, or to modify or to cease participation in this Plan, and shall be given a reasonable period of time in which to exercise such right: such period of time shall be known as the Annual Election Period. The date that the Annual Election Period commences and ends will be set forth in the SPD or the enrollment material. An election is made during the Annual Election Period in the manner set forth in the SPD. The consequences of failing to make an election during the Annual Election Period will be set forth in the SPD.

3.04 **Change of Elections.** A Participant shall not make any changes to the Pre-tax Contribution amount or, where applicable, to the Participant's elected allocation of Nonelective Contributions except for election changes permitted under this Section 3.04, and for changes made during the Annual Election Period (Section 3.03), changes caused by termination of employment (Section 3.05) and changes pursuant to the Family and Medical Leave Act (Section 2.04).

Except as provided in the SPD for HIPAA special enrollment rights arising from the birth, adoption, or placement for adoption of a child, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the first pay period coinciding with or immediately following the date that the election change was filed) but, as determined by the Plan Administrator, election changes may become effective later to the extent the coverage in the applicable component plan commences later. The circumstances under which a Participant may change his election under this Plan are set forth in the SPD.

3.05 **Impact of Termination of Employment on Election or Cessation of Eligibility.** Termination of employment or cessation of eligibility shall automatically revoke any Pre-tax Contributions. Except as provided below, if revocation occurs under this Section 3.05, no new election with respect to Pre-Tax Contributions may be made by such Participant during the remainder of the Plan Year. Rules governing elections for former participants rehired during the same Plan Year shall be set forth in the SPD.

ARTICLE IV - BENEFIT FUNDING

4.01 **Source of Benefit Funding.** The cost of coverage under the component Benefit Plans or Policies shall be funded by the Participant's Pre-tax and/or After-tax Contributions and/or any Nonelective Contributions provided by the Employer. The required contributions for each of the Benefit Plans or Policies offered under the Plan shall be made known to employees in enrollment materials. Pre-tax or After-tax Contributions (as elected by the Employee on the PDA) shall equal the contributions required from the Participant less any available Nonelective Contributions allocated thereto by the Employer, or where applicable, the Participant for coverage of the Participant or the Participant's Spouse or Dependents under the Benefit Plans or Policies elected by the Participant under this Plan. Amounts withheld from a Participant's Compensation as Pre-tax Contributions or After-tax Contributions shall be applied to fund benefits as soon as administratively feasible. The maximum amount of Pre-tax Contributions plus any Nonelective Contributions made available by the Employer for Benefit Plan(s) or Policy(ies) offered under this Plan shall not exceed the aggregate cost of the Benefit Plan(s) or Policy(ies) elected by the Employee.

4.02 **Reduction of Certain Elections to Prevent Discrimination**. If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any requirement imposed by the Code or any limitation on Pre-tax Contributions allocable to Key Employees or to Highly Compensated Individuals, the Plan Administrator shall take such action(s) as he deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification or revocation of a Highly Compensated Individual's or Key Employee's election without the consent of such Employee.

4.03 **Health Care Reimbursement.** To the extent offered under the Plan, each Participant's URM will be credited for Health Care Reimbursement with amounts withheld from the Participant's Compensation and any Nonelective Contributions allocated thereto by the Employer or where applicable, the Participant. The Account will be debited for Health Care Reimbursements disbursed to the Participant in accordance with Article V of this document. The entire amount elected by the Participant on the PDA as an annual amount for the Plan Year for Health Care Reimbursement less any Health Care Reimbursements already disbursed to the participant for Expenses incurred during the Plan Year (plus any grace period or carryover option as set forth in the SPD) shall be available to the Participant at any time during the Plan Year without regard to the balance in the Health Care Account (provided that the periodic contributions have been made). Thus, the maximum amount of Health Care Reimbursement at any particular time during the Plan Year will not relate to the amount that a Participant has had credited to his URM. In no event will the amount of Health Care Reimbursements in any Plan Year (plus any grace period, if applicable, as set forth in the SPD) exceed the annual amount specified for the Plan Year in the PDA for Health Care Reimbursement. Unless the Plan provides for the carry-over option of up to $500 of unused health FSA funds, any amount in excess of the pre-determined carry-over limit credited to the Health Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide Health Care Reimbursement within the grace period (if applicable) and Run-Off period set forth in the SPD. The Plan cannot simultaneously provide for both the grace period option and the carryover option. Amounts so forfeited shall be used in a manner that is permitted within the applicable Department of Labor ("DOL") or Internal Revenue Service ("IRS") regulations. The maximum annual reimbursement under the URM shall be set forth in the SPD. The Employer may establish a minimum annual reimbursement amount as set forth in the SPD. In no event will Participants' PDAs include contributions that exceed the dollar limitations set forth by the IRS.

4.04 **Dependent Care Reimbursement.** To the extent offered under the Plan, each Participant's DDC will be credited for Dependent Care Reimbursement with amounts withheld from the Participant's Compensation, and any Nonelective Contributions allocated thereto by the Employer or where applicable, the Participant. The Dependent Care Account will be debited for Dependent Care Reimbursements disbursed to the Participant in accordance with Article V of this document. In the event that the amount in the Account is less than the amount of reimbursable claims at any time during the Plan Year, the excess part of the claim will be carried over into following months within the same Plan Year, to be paid out as the Dependent Care Account balance becomes adequate. In no event will the amount of Dependent Care Reimbursements exceed the amount credited to the Dependent Care Account for any Plan Year. Any amount allocated to the Dependent Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide Dependent Care Reimbursement for the Plan Year within the Run-Off period set forth in the

SPD. Amounts so forfeited shall be used in a manner that is not prohibited by applicable federal or state law. The maximum annual reimbursement amount shall not exceed the dollar limitations set forth by the IRS.

ARTICLE V - BENEFITS

5.01 Qualified Benefits. The maximum benefit a participant may elect under this Plan shall not exceed the sum of i) the aggregate premium for all Benefit Plan(s) or Policy(ies) set forth in the SPD (other than Health and DDC); ii) any pre-tax HSA contributions (if allowed under the Plan); and iii) the maximum annual Health Care Reimbursement under the URM as set forth in the SPD (if offered under the Plan); and iv) the maximum annual Dependent Care Reimbursement under the DDC as set forth in the SPD (if offered under the Plan.)

(a) **Special Rules for Health Care Reimbursement**. To the extent offered under the Plan, payment shall be made to the Participant in cash as reimbursement for Eligible Medical Expenses incurred by the Participant or his Spouse or Dependents while he is a Participant during the Plan Year (plus any grace period extension as specified in the SPD) for which the Participant's election is effective provided that the substantiation requirements of Section 6.05 herein are satisfied.

(b) **Special Rules for Dependent Care Reimbursement.** To the extent offered under the Plan, payment shall be made to the Participant in cash as reimbursement for Eligible Employment Related Expenses incurred by him while a Participant, during the Plan Year (plus any applicable grace period extension as described in the SPD) for which the Participant's election is effective, provided that the substantiation requirements of Section 6.05 have been satisfied.

5.02 Cash Benefit. To the extent that a Participant does not elect to have the maximum amount of his Compensation contributed as a Pre-tax Contribution or After-tax Contribution hereunder, such amount not elected shall be paid to the Participant in the form of normal Compensation payments; provided, however, that any applicable Nonelective Contributions may not be received in the form of cash compensation, except as otherwise provided for in the SPD or the enrollment material.

5.03 Repayment of Excess Reimbursements. If, as of the end of any Plan Year, it is determined that a Participant has received payments under this Plan that exceed the amount of Eligible Medical Expenses and/or Eligible Employment Related Expenses that have been substantiated by such Participant during the Plan Year as required by Section 6.05 herein, the Plan Administrator shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to the Employer within sixty (60) days of receipt of such notification.

5.04 Termination of Reimbursement Accounts. Coverage under the URM and/or DDC shall cease as of the day in which a Participant is no longer employed by the Employer or when a premium payment for the respective plan(s) has been missed for any reason. Provided, however, that Participants may submit claims under the DDC for reimbursement for Eligible Employment-Related Expenses arising during the Plan Year at any time until the end of the Run-Off period set forth in the SPD. Participants in the URM may submit claims for reimbursement for Eligible Medical Expenses arising during the Plan Year and before the date of separation from service at any time until the end of the Run-Off period set forth in the SPD. Unless a COBRA election is made as set forth in the SPD, Participants shall not be entitled to receive reimbursement for Eligible Medical Expenses incurred after employment ceases under this Section. Any unused reimbursement benefits at the expiration of the Plan Year (as set forth in the SPD) shall be treated in accordance with Sections 4.03 or 4.04.

5.05 Coordination of Benefits Under the URM. The URM is intended to pay benefits solely for otherwise unreimbursed medical expenses. Accordingly, it shall not be considered a group health plan for coordination of benefits purposes, and its benefits shall not be taken into account when determining benefits payable under any other plan.

ARTICLE VI - PLAN ADMINISTRATION

6.01 Allocation of Authority. The Board of Directors or applicable governing body (or an authorized officer of the Employer) appoints a Plan Administrator that keeps the records for the Plan and shall control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising thereunder, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. In the case of an insured Benefit Plan or Policy, the insurer shall be the named fiduciary with respect to benefit claim determinations thereunder, and with respect to benefit claims shall have all of the powers of the Plan Administrator described herein. All determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties:

(a) To require any person to furnish such reasonable information as he may request for the purpose of the proper administration of the Plan as a condition to receiving any benefits under the Plan;

(b) To make and enforce such rules and regulations and prescribe the use of such forms as he shall deem necessary for the efficient administration of the Plan;

(c) To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan and to make or revoke elections under the Plan, in accordance with the provisions of the Plan;

(d) To determine the amount of benefits which shall be payable to any person in accordance with the provisions of the Plan; to inform the Employer or insurer as appropriate, of the amount of such benefits; and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part;

(e) To designate other persons to carry out any duty or power which may or may not otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan. Such entity will be referred to as a third party administrator and shall be identified in the SPD;

(f) To keep records of all acts and determinations, and to keep all such records, books of account, and data and other documents as may be necessary for the proper administration of the Plan; and

(g) To do all things necessary to operate and administer the Plan in accordance with its provisions.

6.02 Payment of Administrative Expenses. Except as otherwise provided in the SPD, the Employer currently pays all reasonable expenses incurred in administering the Plan.

6.03 Reporting and Disclosure Obligations. Unless specified otherwise, it shall be the Employer and Plan Administrator's sole responsibility to comply with all filing, reporting, and disclosure requirements, imposed by the DOL and/or IRS, specifically including, but not limited to creating, filing and distributing Summary Annual Reports, Form 5500s, and SPDs. Furthermore, the Employer and Plan Administrator shall be required to amend the Plan as is necessary to ensure compliance with applicable tax and other laws and regulations.

6.04 Indemnification. The Plan Administrator shall be indemnified by the Employer against claims, and the expenses of defending against such claims, resulting from any action or conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct.

6.05 Substantiation of Expenses. Each Participant must submit a written Claim Form to the Plan Administrator identified in the SPD or its designated plan service provider to receive reimbursements from the URM and/or DDC, on a form provided by the Plan Administrator accompanied by a written statement/bill from an independent third party stating that the expense has been incurred, and the amount thereof. The forms shall contain such evidence, as the Plan Administrator shall deem necessary as to substantiate the nature, the amount, and timeliness of any expenses that may be reimbursed.

6.06 Reimbursement. Reimbursements shall be made as soon as administratively feasible after the required forms have been received by the Plan Administrator identified in the SPD or its designated plan service provider. Reimbursements of less than $15 may be carried forward and aggregated with future reimbursements until the reimbursable amount is greater than $15. However, claims for reimbursements outstanding at the end of the Plan Year (plus any grace period as set forth in the SPD) shall be reimbursed without regard to the $15 threshold limit. Year-end expense reimbursements must be submitted to the Plan Administrator within 90 days of the close of the Plan Year for which the PDA is effective, and during which such expense was incurred, in order to be eligible for reimbursement.

6.07 Annual Statements. The Plan Administrator shall furnish each Participant with an annual statement, showing the amounts paid or expenses incurred by the Employer in providing Medical and/or Dependent Care Expense Reimbursement during the previous calendar year and the respective Reimbursement Account balance(s) on or before January 31 following the close of the applicable Plan Year.

ARTICLE VII - FUNDING AGENT

The Plan shall be funded with amounts withheld from Compensation pursuant to PDAs, and/or Nonelective Contributions provided by the Employer, if any. The Employer will apply all such amounts, without regard to their source, to pay for the welfare benefits provided herein as soon as administratively feasible and shall comply with all applicable regulations promulgated by the DOL taking into consideration any enforcement procedures adopted by the DOL. If a Trust is designated Funding Agent in the SPD, an appropriate Trust Agreement shall be attached at the end of this Plan.

ARTICLE VIII - CLAIMS PROCEDURES

The Plan has established procedures for reviewing claims denied under this Plan and those claims review procedures are set forth in the SPD. The Plan's claim review procedures set forth in the SPD shall only apply to issues germane to the pre-tax benefits available under this Plan (i.e., such as a determination of: a Change in Status; change in cost or coverage; or eligibility

and participation matters under this Cafeteria Plan document), and to the extent offered under the Plan, claims for benefits under the Reimbursement Accounts.

ARTICLE IX - AMENDMENT OR TERMINATION OF PLAN

9.01 **Permanency.** While the Employer fully expects that this Plan will continue indefinitely, due to unforeseen, future business contingencies, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in Sections 9.02 and 9.03 below. Nothing in this Plan is intended to be or shall be construed to entitle any Participant, retired or otherwise, to vested or non-terminable benefits.

9.02 **Employer's Right to Amend.** The Employer reserves the right to amend at any time any or all of the provisions of the Plan. All amendments shall be made in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business (e.g. by approval by the Board of Directors through a meeting or unanimous consent of all Board members). Such amendments may apply retroactively or prospectively as set forth in the amendment. Each Benefit Plan or Policy shall be amended in accordance with the terms specified therein, or, if no amendment procedure is prescribed, in accordance with this section. Any amendment made by the Employer shall be deemed to be approved and adopted by any Affiliated Employer.

9.03 **Employer's Right to Terminate.** The Employer reserves the right to discontinue or terminate the Plan without prejudice at any time and for any reason without prior notice. Such decision to terminate the Plan shall be made in writing and shall be approved by the Employer in accordance with its normal procedures for transacting business. Affiliated Employers may withdraw from participation in the Plan, but may not terminate the Plan.

9.04 **Determination of Effective Date of Amendment or Termination.** Any such amendment, discontinuance, or termination shall be effective as of such date as the Employer shall determine. No amendment, discontinuance or termination shall allow the return to any Employer of any Reimbursement Account balance for its use for any purpose other than for the exclusive benefit of the Participants and their beneficiaries except as provided in Section 4.03 and 4.04 herein.

ARTICLE X - GENERAL PROVISIONS

10.01 **Not an Employment Contract.** Neither this Plan nor any action taken with respect to it shall confer upon any person the right to continue employment with any Employer.

10.02 **Applicable Laws.** The provisions of the Plan shall be construed, administered and enforced according to applicable federal law and the laws of the state of the principal place of business of the Employer to the extent not preempted.

10.03 **Post-Mortem Payments.** Any benefit payable under the Plan after the death of a Participant shall be paid to his surviving spouse (if any), otherwise, to his estate. If there is doubt as to the right of any beneficiary to receive any amount, the Plan Administrator may retain such amount until the rights thereto are determined, without liability for any interest thereon.

10.04 **Nonalienation of Benefits.** Except as expressly provided by the Plan Administrator, no benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements, or torts of any person.

10.05 **Mental or Physical Incompetency.** Every person receiving or claiming benefits under the Plan shall be presumed to be mentally and physically competent and of age until the Plan Administrator receives a written notice, in a form and manner acceptable to it, that such person is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with the care of his estate has been appointed.

10.06 **Inability to Locate Payee.** If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited one year after the date any such payment first became due.

10.07 **Requirement for Proper Forms.** All communications in connection with the Plan made by a Participant shall become effective only when duly executed on any forms as may be required and furnished by, and filed with, the Plan Administrator.

10.08 **Source of Payments.** The Employer, the Trust fund (if selected as Funding Agent), and any insurance company contracts purchased or held by the Employer or funded pursuant to this Plan shall be the sole sources of benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon

termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or beneficiary.

10.09 **Multiple Functions.** Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

10.10 **Tax Effects.** Neither the Employer, its agents, the Plan Administrator, nor the Trustee makes any warranty or other representation as to whether any Pre-tax Premiums made to or on behalf of any Participant hereunder will be treated as excludable from gross income for local, state, or federal income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or Beneficiary is includable in an Employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as a result thereof. The Plan is designed and is intended to be operated as a "cafeteria plan" under Section 125 of the Code.

10.11 **Gender and Number.** Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context.

10.12 **Headings.** The Article and Section headings contained herein are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder.

10.13 **Incorporation by Reference.** Except for the Medical and Dependent Care Expense Reimbursement Plan(s), the actual terms and conditions of the separate component Benefit Plans or Policies offered under this Plan are contained in separate, written documents governing each respective benefit, and shall govern in the event of a conflict between the individual plan document, and this Plan as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein. The provisions of the Medical and Dependent Care Expense Reimbursement Plan(s) are reproduced herein, but shall constitute separate plans for purposes of all applicable Code and ERISA provisions.

10.14 **Severability.** Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder thereof shall be given effect to the maximum extent possible.

10.15 **Effect of Mistake.** In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.

10.16 **Provisions Relating to Insurers.** No insurer shall be required or permitted to issue an insurance policy or contract that is inconsistent with the purposes of this Plan, nor be bound to take any action not in accordance with the terms of any policy or contract with this Plan. The insurer shall not be deemed to be a party to this Plan, nor shall it be bound to interpret the construction or validity of the Plan. The insurer shall be protected from its good faith reliance on the written representations and instructions of the Trustee and the Plan Administrator, and shall not be responsible for the initial or continued qualified status of the Plan.

10.17 **Forfeiture of Unclaimed Reimbursement Account Benefits.** Unless the Employer has implemented a $500 carryover with respect to the URM, any Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Health or Dependent Care Expense was incurred shall be forfeited.

10.18 **HIPAA Privacy.** To the extent a URM is offered under the Plan, the rights and obligations of an individual covered under the URM, the Employer and Plan, with respect to permitted uses and disclosures of a covered individual's protected health information, set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will be summarized in the SPD.

ARTICLE XI - CONTINUATION COVERAGE UNDER COBRA

The SPD includes provisions that shall be applicable to the URM to the extent the URM is a "group health plan" as defined by Code §§ 4980B and 5000(b)(1) and the regulations promulgated thereunder and to the extent it is offered under the Plan. The intent of those provisions (as incorporated in this Article) is to extend continuation rights required by COBRA.

IN WITNESS WHEREOF, the Employer has executed this Plan as of the date set forth below.

EMPLOYER'S ACKNOWLEDGMENT

As evidenced by the formal execution of this document, the undersigned Employer adopted and established this Plan on the Effective Date as the Flexible Benefits Plan of the undersigned Employer. In doing so, the undersigned Employer acknowledges that the Summary Plan Description ("SPD") and this Plan document are important legal instruments with significant legal and tax implications.

The Employer also acknowledges that it has read this SPD and the Plan document in their entirety, has consulted independent legal and tax counsel other than representatives of American Family Life Assurance Company of Columbus (Aflac), to the extent considered necessary, and accepts full responsibility for participation of Employees hereunder and the operation of the Plan. The Employer acknowledges that, as sponsor and Plan Administrator, it shall have sole responsibility to comply with all filing, reporting, and disclosure requirements imposed by the DOL, IRS, or any other government agency, specifically including, but not limited to, creating and filing Form 5500s and preparing and distributing SPDs and performing required nondiscrimination testing.

Furthermore, the Employer further acknowledges that it shall bear sole responsibility for amending the Plan as necessary to ensure compliance with applicable tax, labor, and other laws and regulations. The Employer acknowledges receipt of the checklist of Plan Sponsor Responsibilities included provided with the applicable plan document request form and has agreed to the obligations set forth therein.

It is also understood and agreed that American Family Life Assurance Company of Columbus (Aflac), and its subsidiaries, agents, and representatives, are not providing legal or tax advice to the undersigned Employer in connection with this Plan and that no representations are made by it with respect to the operation of the Flexible Benefits Plan pursuant to the documents provided by American Family Life Assurance Company of Columbus (Aflac) to the Employer.

This Plan shall be construed and enforced according to the Internal Revenue Code of 1986, as amended from time to time, the applicable regulations thereto, and the laws of the state of the principal place of business of the Employer.

IN WITNESS WHEREOF, the Employer has caused this Plan and Summary Plan Description to be executed on the day of 28th. September to ratify the adoption of the Plan adopted and effective as of the Effective Date.

WITNESS:

Corporate Officer

Employer: Blackwater Community School
Peggy Huff

By: PEGGY HUFF

Title: HR MANAGER

Date: Sept. 28, 2015

ATTACHMENT I - SUMMARY PLAN DESCRIPTION