

**THIS IS AN AMENDED AND RESTATED
HEALTH BENEFIT PLAN
FOR**

**DETROIT ACADEMY OF
ARTS & SCIENCES**

Effective Date of Amended and Restated Plan:

October 1, 2016

Group Number: G-1087

SPECIAL NOTE ON CLAIM FILING

ALL BILLS MUST BE SUBMITTED TO THE PLAN WITHIN 12 MONTHS FROM THE DATE THE CHARGES WERE INCURRED IN ORDER TO BE CONSIDERED FOR PAYMENT (EXCEPT AS REQUIRED BY LAW, e.g., MEDICARE/MEDICAID).

This requirement regarding the time period for filing claims shall supersede any other provision in the Plan document regarding the specific time period allowed for submitting bills or filing claims.

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INTRODUCTION

DETROIT ACADEMY OF ARTS & SCIENCES has established the Health Benefit Plan for Detroit Academy of Arts & Sciences as a self-funded employer group health plan in order to provide certain benefits for certain Employees and their eligible Dependents. Detroit Academy of Arts & Sciences executes this amended and restated document, including any future addenda, to re-establish this Plan for the exclusive benefit of the participating Employees and their Dependents. This document is also considered to be the Summary Plan Description and is intended to explain the Plan. Please read this document carefully and acquaint your Family with its provisions.

This Plan is not an arrangement whereby each enrollee is covered by insurance. Instead, the Employer funds claims. Insurance may be purchased to protect the Employer against large claims. However, if for some reason the medical expenses that are eligible for payment under the Plan are not paid, the individuals covered by the Plan could ultimately be responsible for those expenses.

NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The Named Fiduciary and Plan Administrator is **DETROIT ACADEMY OF ARTS & SCIENCES**. The Plan Administrator shall have the authority and discretion to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan.

CLAIM ADMINISTRATOR

The Claim Administrator of the Plan is **ASR HEALTH BENEFITS (ASR)**. The Claim Administrator shall only have the responsibilities delegated to it in writing in an Administration Agreement or other written agreement. The Claim Administrator is not a fiduciary.

The Claim Administrator processes claims and does not insure that any medical expenses of Covered Persons will be paid.

PLAN ADMINISTRATOR'S OBLIGATIONS

The Plan Administrator shall pay all benefits and expenses of the Plan from its general assets. The Plan Administrator does not establish a separate fund for the payment of Plan benefits.

OTHER BASIC INFORMATION ABOUT THE PLAN

- | | |
|--|--|
| 1. <i>Plan Name:</i> | Health Benefit Plan for Detroit Academy of Arts & Sciences |
| 2. <i>Group Number:</i> | G-1087 |
| 3. <i>Employer Identification No.:</i> | 38-3364099 |

4. *Employer/Plan Sponsor/
Plan Administrator:* Detroit Academy of Arts & Sciences
2985 East Jefferson Avenue
Detroit, Michigan 48207
(313) 259-1744
5. *Type of Plan:* Welfare Benefit Plan providing medical benefits
6. *Claim Administrator:* ASR Health Benefits
P.O. Box 6392
Grand Rapids, Michigan 49516-6392
(616) 957-1751 or (800) 968-2449
www.asrhealthbenefits.com
7. *Type of Administration:* The Claim Administrator administers claims for benefits pursuant to a contract with the Plan Administrator.
8. *Agent for Service of
Legal Process:* Human Resource Director
Detroit Academy of Arts & Sciences
2985 East Jefferson Avenue
Detroit, Michigan 48207

Service of process may be made upon the Plan Administrator.
9. *Effective Date of Amended
and Restated Plan:* October 1, 2016
10. *Plan Year:* October 1 through September 30, although the Calendar Year is used for many benefit limitations.

PLEASE NOTE: THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION DESCRIBES THE CIRCUMSTANCES WHEN THE PLAN PAYS FOR HEALTH CARE. THERE MAY BE CIRCUMSTANCES WHEN YOU AND YOUR PHYSICIAN DETERMINE THAT HEALTH CARE THAT IS NOT COVERED BY THIS PLAN IS APPROPRIATE. REMEMBER THAT ALL DECISIONS REGARDING YOUR HEALTH CARE ARE UP TO YOU AND YOUR PHYSICIAN.

HOW TO FILE A MEDICAL CLAIM

If the bill is not being submitted directly by the provider, please submit itemized copies of any bills that have been incurred to the Claim Administrator, ASR Health Benefits (ASR), at the following address:

P.O. Box 6392
Grand Rapids, Michigan 49516-6392
(616) 957-1751, or (800) 968-2449

If the claim is for an Injury, additional information will be required in order to proceed with processing. You must provide information in writing, detailing how, when, and where the Injury was received. Failure to provide this information may delay the timely processing of the claim.

CLAIMS HANDLING

Complete and proper claims for benefits made by Covered Persons will be promptly processed but in the event there are delays in processing claims, Covered Persons shall have no greater rights to interest or other remedies against the Claim Administrator than as otherwise afforded by law.

All information will be reviewed promptly. The Plan Administrator or ASR may request missing or additional data if needed. The Plan Administrator or ASR reserves the right to require an original claim form or billing statement.

In order for any bill to be considered, the bill must be complete. Make sure that the bill shows the patient's full name, the date that services were rendered or purchases made, the diagnosis, the type of care or supply received, and the cost per item.

Generally, the provider of service (Hospital, Physician, laboratory, etc.) will be automatically reimbursed unless proof of prior payment is submitted when the claim is filed. Once a claim is processed, ASR will, acting on behalf of the Plan Administrator, send the Employer or the Participant a check for the amount due and/or an "Explanation of Benefits" that is issued to others on behalf of the Covered Person. The Plan Administrator reserves the right to pay the approved portion directly to the Participant. Be sure to check for amounts that the Covered Person may be responsible for paying.

Try to keep copies of all bills and to submit expense claims to ASR as soon as each bill is received, even if the Deductible has not yet been met. Please read this booklet before a claim occurs because certain expenses are not covered under the Plan. If you have any questions, be sure to ask the Employer or ASR.

BENEFITS

Benefits are described and are subject to the terms and conditions set forth in the pages that follow. In-Network benefits are based on network-contracted rates, and Out-of-Network benefits are based on Usual and Customary charges.

SCHEDULE OF MEDICAL BENEFITS – PLAN A

IMPORTANT!!

- 1. If a Covered Person chooses to be treated by an Out-of-Network Provider, services and treatment provided by the Out-of-Network Provider are not eligible under the Plan unless specifically stated otherwise. Any eligible Out-of-Network charges incurred by a Covered Person will be paid at the In-Network benefit level but will be subject to the Plan's Usual and Customary limitations.**

SCHEDULE OF MEDICAL BENEFITS – PLAN A, cont.

- 2. If a Covered Person receives eligible treatment at an In-Network facility, any anesthesiology, pathology, or radiology charges will be paid at the In-Network benefit level, even if Out-of-Network Providers performed those services.**
- 3. Eligible charges for the following Outpatient services that are performed by an In-Network Provider and billed with a place of service code 11 (Physician’s office) will be paid at 100% with the Deductible waived: miscellaneous medical supplies, anesthesia, surgery, injections, diagnostic X-rays, and diagnostic lab tests. However, the co-payment applicable to the Physician’s exam charge, if any, will still be assessed.**
- 4. Certification is required for all Inpatient Hospital admissions and for some Outpatient procedures. Please see “Utilization Review Program” on page 35 for specific information regarding requirements and deadlines.**

BENEFITS

IN-NETWORK

COMPREHENSIVE MEDICAL

Deductible per Plan Year	\$1,000/Covered Person \$2,000/Family
--------------------------	--

Benefit Covered specifically stated otherwise)	Percentage Paid (all Expenses, unless specifically stated otherwise)	80% after Deductible (20% Coinsurance)
--	--	--

Total Maximum Out-of-Pocket per Plan Year (includes Deductible, Coinsurance, and medical and prescription drug co-payments)	\$3,000/Covered Person \$6,000/Family
---	--

NOTE: The Deductible and Total Maximum Out-of-Pocket do not include expenses that constitute a penalty for noncompliance, exceed the Usual and Customary charge allowed by the Plan, exceed the limits in the Schedule of Benefits, or are otherwise excluded under the provisions of the Plan.

SCHEDULE OF MEDICAL BENEFITS – PLAN A, cont.

BENEFITS	IN-NETWORK
<i>HOSPITAL</i>	
	80% after Deductible
Mandatory Hospital Certification	Required
<hr/>	
Room and Board	Network-contracted rate
<hr/>	
<i>OBSTETRICAL SERVICES</i>	
▪ <i>Physician's Fee for Prenatal and Postnatal Care</i>	\$20 co-payment per visit, then 100% (Deductible waived)
<hr/>	
▪ <i>Physician's Fee for Delivery</i>	100% after Deductible
<hr/>	
▪ <i>All Other Services Billed by the Physician in Connection with the Pregnancy</i>	Paid the same as any other Illness; cost-sharing provisions such as Deductibles, Coinsurance, or co-payments may apply depending upon the type of service rendered

NOTES:

1. If prenatal care, delivery, and postnatal care services are consolidated for billing purposes (i.e., one charge is billed for all services), the claim will initially be paid as a surgical charge. The provider will need to resubmit the claim with separate charges for each service in order for the benefits above to apply. Eligible charges for prenatal care, delivery, and postnatal care services that are not consolidated for billing purposes will be paid as stated above.

2. In accordance with federal law, certain screening, counseling, and behavioral intervention services will be covered as described in the Routine Preventive Care benefit (see the preventive care summary on the Claim Administrator's Website for a list of these services).

SCHEDULE OF MEDICAL BENEFITS – PLAN A, cont.

BENEFITS

IN-NETWORK

EMERGENCY ROOM CARE (In-Network and Out-of-Network claims are eligible)

- *Physician's Fee for an Examination in the Emergency Room* Deductible applies, then \$100 co-payment* per visit, with the balance of the charge paid at 100%
- *All Other Charges Billed by the Physician in Connection with the Emergency Room Treatment* 80% after Deductible

*The co-payment shall be waived if the Covered Person is admitted as an Inpatient from the emergency room.

-
- *Hospital's Fee for the Use of the Emergency Room* 80% after Deductible
 - *All Other Services Billed by the Hospital or Any Other Provider in Connection with the Emergency Room Visit* 80% after Deductible

AMBULANCE TRANSPORTATION 80% after Deductible
(In-Network and Out-of-Network claims are eligible)

URGENT CARE CENTER VISITS

- *Physician's Fee for an Examination* \$60 co-payment per visit, then 100% (Deductible waived)
 - *All Other Charges Billed in Connection with the Examination* Paid the same as any other Illness; cost-sharing provisions such as Deductibles, Coinsurance, or co-payments may apply depending upon the type of service rendered
-

SCHEDULE OF MEDICAL BENEFITS – PLAN A, cont.

BENEFITS

IN-NETWORK

OUTPATIENT PHYSICIAN VISITS

- *Non-Specialist’s Fee for an Examination* \$20 co-payment per visit, then 100% (Deductible waived)

- *Specialist’s Fee for an Examination* Deductible applies, then \$30 co-payment per visit, with the balance of the charge paid at 100%

- *All Other Charges Billed in Connection with the Examination* Paid the same as any other Illness; cost-sharing provisions such as Deductibles, Coinsurance, or co-payments may apply depending upon the type of service rendered

NOTE: The term “non-specialist” means a Physician, Physician’s Assistant, Nurse Practitioner, or other eligible provider who provides medical care in family practice, general practice, Outpatient or Intensive Outpatient Behavioral Care services, internal medicine, obstetrics and gynecology, or pediatrics. For the purposes of this benefit, the term “medical care” does not include any services otherwise addressed in this document (e.g., chiropractic care). The term “specialist” means a Physician with advanced education and training in a recognized medical specialty who is not a non-specialist as defined above. Specialists are often licensed or certified in their medical specialty.

OUTPATIENT REHABILITATIVE THERAPIES (*includes Physical, Speech, and Occupational Therapy*) Deductible applies, then \$30 co-payment per visit, with the balance of the charge paid at 100%

NOTE: As used above, the term “visit” includes one or more Rehabilitative Therapy services rendered in a day.

HOME HEALTH CARE Deductible applies, then \$30 co-payment per visit, with the balance of the charge paid at 100%

HOSPICE CARE 100% after Deductible

SCHEDULE OF MEDICAL BENEFITS – PLAN A, cont.

BENEFITS

IN-NETWORK

ALLERGY SERVICES

- *Serum and Testing* 50% after Deductible

- *Injections* \$5 co-payment per visit, then 100% (Deductible waived)

NOTE: As used above, the term “visit” includes one or more allergy injections administered by one provider in a day.

ROUTINE PREVENTIVE CARE 100%; Deductible waived

NOTE: The Routine Preventive Care Benefit will provide coverage, including coverage for services or items billed by an Out-of-Network Provider to the limited extent required by Health Care Reform, for certain evidence-based items (with A or B ratings) in the recommendations of the United States Preventive Services Task Force; Routine immunizations, including those immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-based preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and additional women’s preventive care and screenings in comprehensive guidelines supported by the HRSA.

ROUTINE IMMUNIZATIONS ADMINISTERED IN A PHARMACY OR AT THE DEPARTMENT OF COMMUNITY HEALTH (including any injection fee charge or other immunization-related charges; In-Network and Out-of-Network claims are eligible) 100%; Deductible waived

NOTE: The Covered Person may have to initially pay for these charges in full and then submit the expense directly to the Claim Administrator for reimbursement.

SCHEDULE OF MEDICAL BENEFITS – PLAN A, cont.

BENEFITS

IN-NETWORK

CHIROPRACTIC CARE

- *Spinal Manipulations, Therapy Treatments, and Physician Fees for an Initial or Periodic Evaluation* Deductible applies, then \$30 co-payment per day, with the balance of the charge paid at 100%
-

- *Diagnostic Spinal X-rays* 80% after Deductible
-

Maximum number of visits allowed per Covered Person per Plan Year for all covered chiropractic services 30 visits

NOTE: As used above, the term “visit” includes one or more chiropractic care services rendered by one provider in a day, but does not include a visit where the only service rendered during that visit was chiropractic X-rays.

AUTISM SPECTRUM DISORDER SERVICES

- *Autism Spectrum Disorder Treatment (including but not limited to, Outpatient Physical Therapy, Speech Therapy, Occupational Therapy, nutritional counseling, and Behavioral Care)* Paid the same as any other Illness; cost-sharing provisions such as Deductibles, Coinsurance, or co-payments may apply depending upon the type of service rendered
-

- *Applied Behavioral Analysis (ABA) Treatment (In-Network and Out-of-Network claims are eligible)* Deductible applies, then \$20 co-payment per visit, with the balance of the charge paid at 100%
-

NOTE: The Plan will consider charges for ABA treatment to be eligible for payment (subject to the terms and conditions of the Plan) through the end of the Calendar Year in which the Covered Person reaches 18 years of age. Any ABA treatment charges billed for a patient who is older than this allowance not will be covered under this benefit or any other benefit of the Plan.

SCHEDULE OF MEDICAL BENEFITS – PLAN A, cont.

BENEFITS

IN-NETWORK

TEMPOROMANDIBULAR JOINT 50% after Deductible
DYSFUNCTION

The Plan will also allow for charges for surgery if all other means of generally accepted treatment have been exhausted.

DURABLE MEDICAL EQUIPMENT 50%; Deductible waived
(includes Orthotic or Prosthetic Appliances)

DIABETIC SUPPLIES 50%; Deductible waived

NOTE: When billed with an eligible diagnosis code, charges eligible under the Diabetic Supply benefit include, but are not limited to, insulin pumps and pump supplies, diabetic test strips, lancets and lancet devices, glucose monitors, and glucagon. For additional information about the supplies eligible to be covered under this benefit, the Covered Person can contact the Claim Administrator using the information listed on the health plan identification card.

VOLUNTARY STERILIZATIONS

▪ *Male Covered Persons with Reproductive Capacity* 50% after Deductible

▪ *Female Covered Persons with Reproductive Capacity* Paid the same as any other Routine Preventive Care service

NOTE: The Plan will cover eligible charges for voluntary sterilization of any female Covered Person with reproductive capacity as a Routine Preventive Care expense, as required by Health Care Reform. For any other eligible charge related to a voluntary sterilization, the Plan will only cover such charges for a Participant and his or her Dependent spouse (i.e., charges for a Dependent child are not eligible).

SCHEDULE OF MEDICAL BENEFITS – PLAN A, cont.

BENEFITS

IN-NETWORK

PRESCRIPTION DRUGS

▪ *Prescription Drug Card Program*

Co-payment per generic prescription drug	\$15
Co-payment per brand-name prescription drug	\$50
Co-payment per sexual dysfunction prescription drug	50% of the purchase price
Co-payment per specialty prescription drug	50% of the purchase price

A Covered Person may fill a prescription for up to and including a 30-day supply for the above-stated co-payment amounts. If a prescribing Physician requests more than a 30-day supply of a drug, up to a 90-day supply of a covered prescribed maintenance medication can be purchased at a participating pharmacy for the applicable Mail Service Program co-payment specified below. However, specialty prescription drug purchases will always be limited to a 30-day dispensing supply.

▪ *Mail Service Program*

Co-payment per generic prescription drug	\$30
Co-payment per brand-name prescription drug	\$100
Co-payment per sexual dysfunction prescription drug	50% of the purchase price
Co-payment per specialty prescription drug	50% of the purchase price

The Mail Service Program is specifically designed to provide the Covered Person with maintenance drugs for up to and including a 90-day supply. However, specialty prescription drug purchases will always be limited to a 30-day dispensing supply.

SCHEDULE OF MEDICAL BENEFITS – PLAN A, cont.

BENEFITS

IN-NETWORK

PRESCRIPTION DRUGS, cont.

NOTES:

1. Certain over-the-counter drugs will be covered under the Plan and shall be subject to the generic co-payment listed above. A Physician's prescription for these products is required.
2. The Plan generally provides coverage for certain specialty prescription drugs as specified in the Prescription Agreement between the Employer and the Pharmacy Benefits Manager (PBM); however, special rules may apply in order for such drugs to be covered. Covered Persons prescribed a specialty prescription drug should contact the PBM at the number on the identification card to learn about the special rules that may apply to the drug, including the co-payment that will be charged or other special coverage terms that will apply. As used in this benefit, the term "specialty prescription drug" means a drug identified on the drug list maintained by the PBM that includes drugs typically used to treat complex medical conditions. Specialty prescription drugs may be injectable medications, high-cost medications, or medications with special delivery and storage requirements (e.g., they may require refrigeration). Specialty prescription drug purchases will be limited to a 30-day supply.
3. The pharmacy will dispense generic drugs unless the prescribing Physician requests "Dispense as Written" (DAW) or a generic equivalent is not available. If the Covered Person refuses an available generic equivalent and the prescribing Physician has not requested DAW, the Covered Person must pay the applicable co-payment **plus** the difference in price between the brand-name drug and its generic equivalent.
4. In accordance with the requirements of Health Care Reform, the Plan provides coverage for certain preventive care medications without any cost-sharing provisions such as Deductibles or co-payments. Preventive care medications include, but are not limited to, certain FDA-approved contraceptive agents, certain smoking cessation intervention products when prescribed by a Physician, and breast cancer medications that lower the risk of cancer or slow its development. For more information about eligible preventive care medications, Covered Persons can contact the PBM at the number on the front of the identification card.
5. Effective January 1, 2017, the Plan will require that specific criteria be met before certain high-cost brand-name medications are covered. The Covered Person must have tried a lower-cost PBM-approved equivalent medication before the Plan will cover the brand-name drug. Alternatively, a brand-name drug may be covered if the Covered Person's Physician contacts the PBM and provides evidence of the prior utilization or proof of failed therapy and the PBM authorizes the brand-name medication. If a Covered Person chooses to fill a prescription for certain brand-name drugs without first trying a PBM-approved equivalent medication or getting an authorization from the PBM, coverage may be denied and the Covered Person may have to pay the full cost of the drug.

SCHEDULE OF MEDICAL BENEFITS – PLAN A, cont.

BENEFITS

IN-NETWORK

PRESCRIPTION DRUGS, cont.

6. Certain immunizations administered at a pharmacy within the designated network, including any injection/administration fees charged by the pharmacy, will be covered by the Plan through the Prescription Drug Card Program at 100% (no co-payment will be applied). Covered Persons can contact the PBM for more information on how to find a pharmacy within the designated network that administers these immunizations.

***MAXIMUM BENEFIT PAID PER
COVERED PERSON PER PLAN
YEAR FOR COVERED MEDICAL
EXPENSES***

Unlimited

SCHEDULE OF MEDICAL BENEFITS – PLAN B

IMPORTANT!!

1. If a Covered Person chooses to be treated by an Out-of-Network Provider, services and treatment provided by the Out-of-Network Provider are not eligible under the Plan unless specifically stated otherwise. Any eligible Out-of-Network charges incurred by a Covered Person will be paid at the In-Network benefit level but will be subject to the Plan’s Usual and Customary limitations.
2. If a Covered Person receives eligible treatment at an In-Network facility, any anesthesiology, pathology, or radiology charges will be paid at the In-Network benefit level, even if Out-of-Network Providers performed those services.
3. Eligible charges for the following Outpatient services that are performed by an In-Network Provider and billed with a place of service code 11 (Physician’s office) will be paid at 100% with the Deductible waived: miscellaneous medical supplies, anesthesia, surgery, injections, diagnostic X-rays, and diagnostic lab tests. However, the co-payment applicable to the Physician’s exam charge, if any, will still be assessed.
4. Certification is required for all Inpatient Hospital admissions and for some Outpatient procedures. Please see “Utilization Review Program” on page 35 for specific information regarding requirements and deadlines.

SCHEDULE OF MEDICAL BENEFITS – PLAN B, cont.

BENEFITS

IN-NETWORK

COMPREHENSIVE MEDICAL

Deductible per Plan Year	\$500/Covered Person \$1,000/Family
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Benefit Covered specifically stated otherwise	Percentage Paid (all Expenses, unless specifically stated otherwise)	80% after Deductible (20% Coinsurance)
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Total Maximum Out-of-Pocket per Plan Year (includes Deductible, Coinsurance, and medical and prescription drug co-payments)	\$2,500/Covered Person \$5,000/Family
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NOTE: The Deductible and Total Maximum Out-of-Pocket do not include expenses that constitute a penalty for noncompliance, exceed the Usual and Customary charge allowed by the Plan, exceed the limits in the Schedule of Benefits, or are otherwise excluded under the provisions of the Plan.

HOSPITAL

80% after Deductible

Mandatory Hospital Certification	Required
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Room and Board	Network-contracted rate
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OBSTETRICAL SERVICES

▪ <i>Physician's Fee for Prenatal and Postnatal Care</i>	\$20 co-payment per visit, then 100% (Deductible waived)
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▪ <i>Physician's Fee for Delivery</i>	100% after Deductible
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SCHEDULE OF MEDICAL BENEFITS – PLAN B, cont.

BENEFITS

IN-NETWORK

OBSTETRICAL SERVICES, cont.

- | | |
|--|--|
| <ul style="list-style-type: none">▪ <i>All Other Services Billed by the Physician in Connection with the Pregnancy</i> | Paid the same as any other Illness; cost-sharing provisions such as Deductibles, Coinsurance, or co-payments may apply depending upon the type of service rendered |
|--|--|

NOTES:

1. If prenatal care, delivery, and postnatal care services are consolidated for billing purposes (i.e., one charge is billed for all services), the claim will initially be paid as a surgical charge. The provider will need to resubmit the claim with separate charges for each service in order for the benefits above to apply. Eligible charges for prenatal care, delivery, and postnatal care services that are not consolidated for billing purposes will be paid as stated above.

2. In accordance with federal law, certain screening, counseling, and behavioral intervention services will be covered as described in the Routine Preventive Care benefit (see the preventive care summary on the Claim Administrator’s Website for a list of these services).

EMERGENCY ROOM CARE (*In-Network and Out-of-Network claims are eligible*)

- | | |
|---|--|
| <ul style="list-style-type: none">▪ <i>Physician’s Fee for an Examination in the Emergency Room</i>
▪ <i>All Other Charges Billed by the Physician in Connection with the Emergency Room Treatment</i> | Deductible applies, then \$75 co-payment* per visit, with the balance of the charge paid at 100% |
| | 80% after Deductible |

*The co-payment shall be waived if the Covered Person is admitted as an Inpatient from the emergency room.

-
- | | |
|---|----------------------|
| <ul style="list-style-type: none">▪ <i>Hospital’s Fee for the Use of the Emergency Room</i>
▪ <i>All Other Services Billed by the Hospital or Any Other Provider in Connection with the Emergency Room Visit</i> | 80% after Deductible |
| | 80% after Deductible |
-

SCHEDULE OF MEDICAL BENEFITS – PLAN B, cont.

BENEFITS

IN-NETWORK

<i>AMBULANCE TRANSPORTATION</i> <i>(In-Network and Out-of-Network claims are eligible)</i>	80% after Deductible
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URGENT CARE CENTER VISITS

- | | |
|---|--|
| ▪ <i>Physician’s Fee for an Examination</i> | \$35 co-payment per visit, then 100% (Deductible waived) |
|---|--|
-
- | | |
|--|--|
| ▪ <i>All Other Charges Billed in Connection with the Examination</i> | Paid the same as any other Illness; cost-sharing provisions such as Deductibles, Coinsurance, or co-payments may apply depending upon the type of service rendered |
|--|--|
-

OUTPATIENT PHYSICIAN VISITS

- | | |
|--|--|
| ▪ <i>Non-Specialist’s Fee for an Examination</i> | \$20 co-payment per visit, then 100% (Deductible waived) |
|--|--|
- | | |
|--|---|
| ▪ <i>Specialist’s Fee for an Examination</i> | Deductible applies, then \$20 co-payment per visit, with the balance of the charge paid at 100% |
|--|---|
-
- | | |
|--|--|
| ▪ <i>All Other Charges Billed in Connection with the Examination</i> | Paid the same as any other Illness; cost-sharing provisions such as Deductibles, Coinsurance, or co-payments may apply depending upon the type of service rendered |
|--|--|
-

NOTE: The term “non-specialist” means a Physician, Physician’s Assistant, Nurse Practitioner, or other eligible provider who provides medical care in family practice, general practice, Outpatient or Intensive Outpatient Behavioral Care services, internal medicine, obstetrics and gynecology, or pediatrics. For the purposes of this benefit, the term “medical care” does not include any services otherwise addressed in this document (e.g., chiropractic care). The term “specialist” means a Physician with advanced education and training in a recognized medical specialty who is not a non-specialist as defined above. Specialists are often licensed or certified in their medical specialty.

SCHEDULE OF MEDICAL BENEFITS – PLAN B, cont.

BENEFITS	IN-NETWORK
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OUTPATIENT REHABILITATIVE THERAPIES (<i>includes Physical, Speech, and Occupational Therapy</i>)	Deductible applies, then \$20 co-payment per visit, with the balance of the charge paid at 100%
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NOTE: As used above, the term “visit” includes one or more Rehabilitative Therapy services rendered in a day.

HOME HEALTH CARE	Deductible applies, then \$20 co-payment per visit, with the balance of the charge paid at 100%
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HOSPICE CARE	100% after Deductible
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ALLERGY SERVICES

- | | |
|----------------------------|---|
| ▪ <i>Serum and Testing</i> | 50% after Deductible |
| ▪ <i>Injections</i> | \$5 co-payment per visit, then 100% (Deductible waived) |

NOTE: As used above, the term “visit” includes one or more allergy injections administered by one provider in a day.

ROUTINE PREVENTIVE CARE	100%; Deductible waived
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NOTE: The Routine Preventive Care Benefit will provide coverage, including coverage for services or items billed by an Out-of-Network Provider to the limited extent required by Health Care Reform, for certain evidence-based items (with A or B ratings) in the recommendations of the United States Preventive Services Task Force; Routine immunizations, including those immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-based preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and additional women’s preventive care and screenings in comprehensive guidelines supported by the HRSA.

SCHEDULE OF MEDICAL BENEFITS – PLAN B, cont.

BENEFITS	IN-NETWORK
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<p><i>ROUTINE IMMUNIZATIONS ADMINISTERED IN A PHARMACY OR AT THE DEPARTMENT OF COMMUNITY HEALTH</i> (including any injection fee charge or other immunization-related charges; In-Network and Out-of-Network claims are eligible)</p>	<p>100%; Deductible waived</p>
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NOTE: The Covered Person may have to initially pay for these charges in full and then submit the expense directly to the Claim Administrator for reimbursement.

CHIROPRACTIC CARE

<ul style="list-style-type: none"> ▪ <i>Spinal Manipulations, Therapy Treatments, and Physician Fees for an Initial or Periodic Evaluation</i> 	<p>Deductible applies, then \$20 co-payment per day, with the balance of the charge paid at 100%</p>
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<ul style="list-style-type: none"> ▪ <i>Diagnostic Spinal X-rays</i> 	<p>80% after Deductible</p>
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<p>Maximum number of visits allowed per Covered Person per Plan Year for all covered chiropractic services</p>	<p>30 visits</p>
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NOTE: As used above, the term “visit” includes one or more chiropractic care services rendered by one provider in a day, but does not include a visit where the only service rendered during that visit was chiropractic X-rays.

AUTISM SPECTRUM DISORDER SERVICES

<ul style="list-style-type: none"> ▪ <i>Autism Spectrum Disorder Treatment (including but not limited to, Outpatient Physical Therapy, Speech Therapy, Occupational Therapy, nutritional counseling, and Behavioral Care)</i> 	<p>Paid the same as any other Illness; cost-sharing provisions such as Deductibles, Coinsurance, or co-payments may apply depending upon the type of service rendered</p>
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SCHEDULE OF MEDICAL BENEFITS – PLAN B, cont.

BENEFITS

IN-NETWORK

AUTISM SPECTRUM DISORDER SERVICES, cont.

- *Applied Behavioral Analysis (ABA) Treatment (In-Network and Out-of-Network claims are eligible)* Deductible applies, then \$20 co-payment per visit, with the balance of the charge paid at 100%

NOTE: The Plan will consider charges for ABA treatment to be eligible for payment (subject to the terms and conditions of the Plan) through the end of the Calendar Year in which the Covered Person reaches 18 years of age. Any ABA treatment charges billed for a patient who is older than this allowance not will be covered under this benefit or any other benefit of the Plan.

TEMPOROMANDIBULAR JOINT DYSFUNCTION 50% after Deductible

The Plan will also allow for charges for surgery if all other means of generally accepted treatment have been exhausted.

DURABLE MEDICAL EQUIPMENT 50%; Deductible waived
(includes Orthotic or Prosthetic Appliances)

DIABETIC SUPPLIES 50%; Deductible waived

NOTE: When billed with an eligible diagnosis code, charges eligible under the Diabetic Supply benefit include, but are not limited to, insulin pumps and pump supplies, diabetic test strips, lancets and lancet devices, glucose monitors, and glucagon. For additional information about the supplies eligible to be covered under this benefit, the Covered Person can contact the Claim Administrator using the information listed on the health plan identification card.

VOLUNTARY STERILIZATIONS

- *Male Covered Persons with Reproductive Capacity* 50% after Deductible
-

SCHEDULE OF MEDICAL BENEFITS – PLAN B, cont.

BENEFITS

IN-NETWORK

VOLUNTARY STERILIZATIONS, cont.

- *Female Covered Persons with Reproductive Capacity* Paid the same as any other Routine Preventive Care service

NOTE: The Plan will cover eligible charges for voluntary sterilization of any female Covered Person with reproductive capacity as a Routine Preventive Care expense, as required by Health Care Reform. For any other eligible charge related to a voluntary sterilization, the Plan will only cover such charges for a Participant and his or her Dependent spouse (i.e., charges for a Dependent child are not eligible).

PRESCRIPTION DRUGS

- *Prescription Drug Card Program*

Co-payment per generic prescription drug	\$15
Co-payment per brand-name prescription drug	\$50
Co-payment per sexual dysfunction prescription drug	50% of the purchase price
Co-payment per specialty prescription drug	50% of the purchase price

A Covered Person may fill a prescription for up to and including a 30-day supply for the above-stated co-payment amounts. If a prescribing Physician requests more than a 30-day supply of a drug, up to a 90-day supply of a covered prescribed maintenance medication can be purchased at a participating pharmacy for the applicable Mail Service Program co-payment specified below. However, specialty prescription drug purchases will always be limited to a 30-day dispensing supply.

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- *Mail Service Program*

Co-payment per generic prescription drug	\$30
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SCHEDULE OF MEDICAL BENEFITS – PLAN B, cont.

BENEFITS

IN-NETWORK

PRESCRIPTION DRUGS, cont.

▪ *Mail Service Program, cont.*

Co-payment per brand-name prescription drug	\$100
Co-payment per sexual dysfunction prescription drug	50% of the purchase price
Co-payment per specialty prescription drug	50% of the purchase price

The Mail Service Program is specifically designed to provide the Covered Person with maintenance drugs for up to and including a 90-day supply. However, specialty prescription drug purchases will always be limited to a 30-day dispensing supply.

NOTES:

1. Certain over-the-counter drugs will be covered under the Plan and shall be subject to the generic co-payment listed above. A Physician’s prescription for these products is required.
2. The Plan generally provides coverage for certain specialty prescription drugs as specified in the Prescription Agreement between the Employer and the Pharmacy Benefits Manager (PBM); however, special rules may apply in order for such drugs to be covered. Covered Persons prescribed a specialty prescription drug should contact the PBM at the number on the identification card to learn about the special rules that may apply to the drug, including the co-payment that will be charged or other special coverage terms that will apply. As used in this benefit, the term “specialty prescription drug” means a drug identified on the drug list maintained by the PBM that includes drugs typically used to treat complex medical conditions. Specialty prescription drugs may be injectable medications, high-cost medications, or medications with special delivery and storage requirements (e.g., they may require refrigeration). Specialty prescription drug purchases will be limited to a 30-day supply.
3. The pharmacy will dispense generic drugs unless the prescribing Physician requests “Dispense as Written” (DAW) or a generic equivalent is not available. If the Covered Person refuses an available generic equivalent and the prescribing Physician has not requested DAW, the Covered Person must pay the applicable co-payment plus the difference in price between the brand-name drug and its generic equivalent.

SCHEDULE OF MEDICAL BENEFITS – PLAN B, cont.

BENEFITS

IN-NETWORK

PRESCRIPTION DRUGS, cont.

4. In accordance with the requirements of Health Care Reform, the Plan provides coverage for certain preventive care medications without any cost-sharing provisions such as Deductibles or co-payments. Preventive care medications include, but are not limited to, certain FDA-approved contraceptive agents, certain smoking cessation intervention products when prescribed by a Physician, and breast cancer medications that lower the risk of cancer or slow its development. For more information about eligible preventive care medications, Covered Persons can contact the PBM at the number on the front of the identification card.

5. Effective January 1, 2017, the Plan will require that specific criteria be met before certain high-cost brand-name medications are covered. The Covered Person must have tried a lower-cost PBM-approved equivalent medication before the Plan will cover the brand-name drug. Alternatively, a brand-name drug may be covered if the Covered Person's Physician contacts the PBM and provides evidence of the prior utilization or proof of failed therapy and the PBM authorizes the brand-name medication. If a Covered Person chooses to fill a prescription for certain brand-name drugs without first trying a PBM-approved equivalent medication or getting an authorization from the PBM, coverage may be denied and the Covered Person may have to pay the full cost of the drug.

6. Certain immunizations administered at a pharmacy within the designated network, including any injection/administration fees charged by the pharmacy, will be covered by the Plan through the Prescription Drug Card Program at 100% (no co-payment will be applied). Covered Persons can contact the PBM for more information on how to find a pharmacy within the designated network that administers these immunizations.

***MAXIMUM BENEFIT PAID PER
COVERED PERSON PER PLAN
YEAR FOR COVERED MEDICAL
EXPENSES***

Unlimited

SCHEDULE OF MEDICAL BENEFITS – PLAN C

IMPORTANT!!

1. If a Covered Person chooses to be treated by an Out-of-Network Provider, services and treatment provided by the Out-of-Network Provider are not eligible under the Plan unless specifically stated otherwise. Any eligible Out-of-Network charges incurred by a Covered Person will be paid at the In-Network benefit level but will be subject to the Plan’s Usual and Customary limitations.

2. If a Covered Person receives eligible treatment at an In-Network facility, any anesthesiology, pathology, or radiology charges will be paid at the In-Network benefit level, even if Out-of-Network Providers performed those services.

3. Eligible charges for the following Outpatient services that are performed by an In-Network Provider and billed with a place of service code 11 (Physician’s office) will be paid at 100% with the Deductible (if any), waived: miscellaneous medical supplies, anesthesia, surgery, injections, diagnostic X-rays, and diagnostic lab tests. However, the co-payment applicable to the Physician’s exam charge, if any, will still be assessed.

4. Certification is required for all Inpatient Hospital admissions and for some Outpatient procedures. Please see “Utilization Review Program” on page 35 for specific information regarding requirements and deadlines.

BENEFITS

IN-NETWORK

COMPREHENSIVE MEDICAL

Deductible per Plan Year	\$-0-/Covered Person \$-0-/Family
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Benefit Covered specifically stated otherwise)	Percentage Paid (all Expenses, unless)	100% (0% Coinsurance)
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Total Maximum Out-of-Pocket per Plan Year (includes Deductible [if any], Coinsurance, and medical and prescription drug co-payments)	\$6,350/Covered Person \$12,700/Family
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SCHEDULE OF MEDICAL BENEFITS – PLAN C, cont.

BENEFITS

IN-NETWORK

COMPREHENSIVE MEDICAL, cont.

NOTE: The Deductible (if any) and Total Maximum Out-of-Pocket do not include expenses that constitute a penalty for noncompliance, exceed the Usual and Customary charge allowed by the Plan, exceed the limits in the Schedule of Benefits, or are otherwise excluded under the provisions of the Plan.

HOSPITAL

100%

Mandatory Hospital Certification

Required

Room and Board

Network-contracted rate

OBSTETRICAL SERVICES

▪ *Physician's Fee for Prenatal and Postnatal Care* \$30 co-payment per visit, then 100%

▪ *Physician's Fee for Delivery* 100%

▪ *All Other Services Billed by the Physician in Connection with the Pregnancy* Paid the same as any other Illness; cost-sharing provisions such as Deductibles (if any), Coinsurance, or co-payments may apply depending upon the type of service rendered

NOTES:

1. If prenatal care, delivery, and postnatal care services are consolidated for billing purposes (i.e., one charge is billed for all services), the claim will initially be paid as a surgical charge. The provider will need to resubmit the claim with separate charges for each service in order for the benefits above to apply. Eligible charges for prenatal care, delivery, and postnatal care services that are not consolidated for billing purposes will be paid as stated above.

2. In accordance with federal law, certain screening, counseling, and behavioral intervention services will be covered as described in the Routine Preventive Care benefit (see the preventive care summary on the Claim Administrator's Website for a list of these services).

SCHEDULE OF MEDICAL BENEFITS – PLAN C, cont.

BENEFITS

IN-NETWORK

EMERGENCY ROOM CARE (*In-Network and Out-of-Network claims are eligible*)

- *Physician's Fee for an Examination in the Emergency Room* \$100 co-payment* per visit, then 100%
- *All Other Charges Billed by the Physician in Connection with the Emergency Room Treatment* 100%

*The co-payment shall be waived if the Covered Person is admitted as an Inpatient from the emergency room.

-
- *Hospital's Fee for the Use of the Emergency Room* 100%
 - *All Other Services Billed by the Hospital or Any Other Provider in Connection with the Emergency Room Visit* 100%

AMBULANCE TRANSPORTATION 100%
(*In-Network and Out-of-Network claims are eligible*)

URGENT CARE CENTER VISITS

- *Physician's Fee for an Examination* \$50 co-payment per visit, then 100%
 - *All Other Charges Billed in Connection with the Examination* Paid the same as any other Illness; cost-sharing provisions such as Deductibles (if any), Coinsurance, or co-payments may apply depending upon the type of service rendered
-

SCHEDULE OF MEDICAL BENEFITS – PLAN C, cont.

BENEFITS

IN-NETWORK

OUTPATIENT PHYSICIAN VISITS

- *Non-Specialist’s Fee for an Examination* \$30 co-payment per visit, then 100%
- *Specialist’s Fee for an Examination* \$30 co-payment per visit, then 100%

-
- *All Other Charges Billed in Connection with the Examination* Paid the same as any other Illness; cost-sharing provisions such as Deductibles (if any), Coinsurance, or co-payments may apply depending upon the type of service rendered

NOTE: The term “non-specialist” means a Physician, Physician’s Assistant, Nurse Practitioner, or other eligible provider who provides medical care in family practice, general practice, Outpatient or Intensive Outpatient Behavioral Care services, internal medicine, obstetrics and gynecology, or pediatrics. For the purposes of this benefit, the term “medical care” does not include any services otherwise addressed in this document (e.g., chiropractic care). The term “specialist” means a Physician with advanced education and training in a recognized medical specialty who is not a non-specialist as defined above. Specialists are often licensed or certified in their medical specialty.

OUTPATIENT REHABILITATIVE THERAPIES \$30 co-payment per visit, then 100%
(includes Physical, Speech, and Occupational Therapy)

NOTE: As used above, the term “visit” includes one or more Rehabilitative Therapy services rendered in a day.

HOME HEALTH CARE \$30 co-payment per visit, then 100%

HOSPICE CARE 100%

SCHEDULE OF MEDICAL BENEFITS – PLAN C, cont.

BENEFITS

IN-NETWORK

ALLERGY SERVICES

- *Serum and Testing* 100%

-
- *Injections* \$5 co-payment per visit, then 100%

NOTE: As used above, the term “visit” includes one or more allergy injections administered by one provider in a day.

ROUTINE PREVENTIVE CARE 100%

NOTE: The Routine Preventive Care Benefit will provide coverage, including coverage for services or items billed by an Out-of-Network Provider to the limited extent required by Health Care Reform, for certain evidence-based items (with A or B ratings) in the recommendations of the United States Preventive Services Task Force; Routine immunizations, including those immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-based preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and additional women’s preventive care and screenings in comprehensive guidelines supported by the HRSA.

ROUTINE IMMUNIZATIONS ADMINISTERED IN A PHARMACY OR AT THE DEPARTMENT OF COMMUNITY HEALTH (including any injection fee charge or other immunization-related charges; In-Network and Out-of-Network claims are eligible) 100%

NOTE: The Covered Person may have to initially pay for these charges in full and then submit the expense directly to the Claim Administrator for reimbursement.

SCHEDULE OF MEDICAL BENEFITS – PLAN C, cont.

BENEFITS

IN-NETWORK

CHIROPRACTIC CARE

- *Spinal Manipulations, Therapy Treatments, and Physician Fees for an Initial or Periodic Evaluation* \$30 co-payment per day, then 100%
-

- *Diagnostic Spinal X-rays* 100%
-

Maximum number of visits allowed per Covered Person per Plan Year for all covered chiropractic services 30 visits

NOTE: As used above, the term “visit” includes one or more chiropractic care services rendered by one provider in a day, but does not include a visit where the only service rendered during that visit was chiropractic X-rays.

AUTISM SPECTRUM DISORDER SERVICES

- *Autism Spectrum Disorder Treatment (including but not limited to, Outpatient Physical Therapy, Speech Therapy, Occupational Therapy, nutritional counseling, and Behavioral Care)* Paid the same as any other Illness; cost-sharing provisions such as Deductibles (if any), Coinsurance, or co-payments may apply depending upon the type of service rendered
-

- *Applied Behavioral Analysis (ABA) Treatment (In-Network and Out-of-Network claims are eligible)* \$30 co-payment per visit, then 100%

NOTE: The Plan will consider charges for ABA treatment to be eligible for payment (subject to the terms and conditions of the Plan) through the end of the Calendar Year in which the Covered Person reaches 18 years of age. Any ABA treatment charges billed for a patient who is older than this allowance not will be covered under this benefit or any other benefit of the Plan.

SCHEDULE OF MEDICAL BENEFITS – PLAN C, cont.

BENEFITS

IN-NETWORK

TEMPOROMANDIBULAR JOINT DYSFUNCTION 50%

The Plan will also allow for charges for surgery if all other means of generally accepted treatment have been exhausted.

DURABLE MEDICAL EQUIPMENT 50%
(includes Orthotic or Prosthetic Appliances)

DIABETIC SUPPLIES 50%

NOTE: When billed with an eligible diagnosis code, charges eligible under the Diabetic Supply benefit include, but are not limited to, insulin pumps and pump supplies, diabetic test strips, lancets and lancet devices, glucose monitors, and glucagon. For additional information about the supplies eligible to be covered under this benefit, the Covered Person can contact the Claim Administrator using the information listed on the health plan identification card.

VOLUNTARY STERILIZATIONS

▪ *Male Covered Persons with Reproductive Capacity* 50%

▪ *Female Covered Persons with Reproductive Capacity* Paid the same as any other Routine Preventive Care service

NOTE: The Plan will cover eligible charges for voluntary sterilization of any female Covered Person with reproductive capacity as a Routine Preventive Care expense, as required by Health Care Reform. For any other eligible charge related to a voluntary sterilization, the Plan will only cover such charges for a Participant and his or her Dependent spouse (i.e., charges for a Dependent child are not eligible).

SCHEDULE OF MEDICAL BENEFITS – PLAN C, cont.

BENEFITS

IN-NETWORK

PRESCRIPTION DRUGS

- *Prescription Drug Card Program*

Co-payment per generic prescription drug	\$10
Co-payment per brand-name prescription drug	\$40
Co-payment per sexual dysfunction prescription drug	50% of the purchase price
Co-payment per specialty prescription drug	50% of the purchase price

A Covered Person may fill a prescription for up to and including a 30-day supply for the above-stated co-payment amounts. If a prescribing Physician requests more than a 30-day supply of a drug, up to a 90-day supply of a covered prescribed maintenance medication can be purchased at a participating pharmacy for the applicable Mail Service Program co-payment specified below. However, specialty prescription drug purchases will always be limited to a 30-day dispensing supply.

- *Mail Service Program*

Co-payment per generic prescription drug	\$20
Co-payment per brand-name prescription drug	\$80
Co-payment per sexual dysfunction prescription drug	50% of the purchase price
Co-payment per specialty prescription drug	50% of the purchase price

The Mail Service Program is specifically designed to provide the Covered Person with maintenance drugs for up to and including a 90-day supply. However, specialty prescription drug purchases will always be limited to a 30-day dispensing supply.

SCHEDULE OF MEDICAL BENEFITS – PLAN C, cont.

BENEFITS

IN-NETWORK

PRESCRIPTION DRUGS, cont.

NOTES:

1. Certain over-the-counter drugs will be covered under the Plan and shall be subject to the generic co-payment listed above. A Physician's prescription for these products is required.
2. The Plan generally provides coverage for certain specialty prescription drugs as specified in the Prescription Agreement between the Employer and the Pharmacy Benefits Manager (PBM); however, special rules may apply in order for such drugs to be covered. Covered Persons prescribed a specialty prescription drug should contact the PBM at the number on the identification card to learn about the special rules that may apply to the drug, including the co-payment that will be charged or other special coverage terms that will apply. As used in this benefit, the term "specialty prescription drug" means a drug identified on the drug list maintained by the PBM that includes drugs typically used to treat complex medical conditions. Specialty prescription drugs may be injectable medications, high-cost medications, or medications with special delivery and storage requirements (e.g., they may require refrigeration). Specialty prescription drug purchases will be limited to a 30-day supply.
3. The pharmacy will dispense generic drugs unless the prescribing Physician requests "Dispense as Written" (DAW) or a generic equivalent is not available. If the Covered Person refuses an available generic equivalent and the prescribing Physician has not requested DAW, the Covered Person must pay the applicable co-payment plus the difference in price between the brand-name drug and its generic equivalent.
4. In accordance with the requirements of Health Care Reform, the Plan provides coverage for certain preventive care medications without any cost-sharing provisions such as Deductibles or co-payments. Preventive care medications include, but are not limited to, certain FDA-approved contraceptive agents, certain smoking cessation intervention products when prescribed by a Physician, and breast cancer medications that lower the risk of cancer or slow its development. For more information about eligible preventive care medications, Covered Persons can contact the PBM at the number on the front of the identification card.
5. Effective January 1, 2017, the Plan will require that specific criteria be met before certain high-cost brand-name medications are covered. The Covered Person must have tried a lower-cost PBM-approved equivalent medication before the Plan will cover the brand-name drug. Alternatively, a brand-name drug may be covered if the Covered Person's Physician contacts the PBM and provides evidence of the prior utilization or proof of failed therapy and the PBM authorizes the brand-name medication. If a Covered Person chooses to fill a prescription for certain brand-name drugs without first trying a PBM-approved equivalent medication or getting an authorization from the PBM, coverage may be denied and the Covered Person may have to pay the full cost of the drug.

SCHEDULE OF MEDICAL BENEFITS – PLAN C, cont.

BENEFITS

IN-NETWORK

PRESCRIPTION DRUGS, cont.

6. Certain immunizations administered at a pharmacy within the designated network, including any injection/administration fees charged by the pharmacy, will be covered by the Plan through the Prescription Drug Card Program at 100% (no co-payment will be applied). Covered Persons can contact the PBM for more information on how to find a pharmacy within the designated network that administers these immunizations.

***MAXIMUM BENEFIT PAID PER
COVERED PERSON PER PLAN
YEAR FOR COVERED MEDICAL
EXPENSES***

Unlimited

**COORDINATION WITH OTHER COVERAGE FOR INJURIES ARISING OUT OF
AUTOMOBILE ACCIDENTS**

Notwithstanding the Payment Priorities rules set forth in the General Provisions section, the following special coordination rule applies regarding automobile insurance. If a Covered Person has automobile insurance (including, but not limited to no-fault) that provides health benefits, this Plan shall be the primary plan and the automobile insurance shall be the secondary plan for purposes of paying benefits.

HEALTH CARE REFORM

The Plan complies with the insurance market-related provisions of Health Care Reform. The required provisions include the following:

- A. The Plan allows eligible Dependent children to continue to participate in the Plan through the end of the month in which the child's 26th birthday occurs.
- B. The Plan will not impose an annual or Lifetime limit on the dollar value of an Essential Health Benefit.
- C. Coverage will not be retroactively rescinded except as permitted by law, for example, in cases of fraud, intentional misrepresentation, or failure to timely pay required premiums for coverage. Notice that coverage will be retroactively rescinded must be provided 30 days before proceeding with the termination process.

- D. The Plan will not impose a pre-existing condition limitation or exclusion on any otherwise eligible claim.
- E. The Plan will not impose a waiting period for coverage that exceeds 90 calendar days, including weekends and holidays. Coverage under a group health plan must begin no later than the 91st day after an employee meets all of the plan's eligibility requirements.
- F. This Plan option is not a grandfathered plan under Health Care Reform. Accordingly, the following additional insurance market reforms under Health Care Reform apply:
1. The Plan provides certain preventive care items and services without required Participant cost-sharing.
 2. The Plan provides certain patient protections such as:
 - If a Covered Person is required to designate a Personal Care Physician (PCP), the Covered Person may designate any participating PCP, including a Pediatrician, as the Covered Person's PCP.
 - The Plan does not require a preauthorization or referral when a Covered Person seeks coverage for obstetric or gynecological care from an In-Network OB-GYN.
 - The Plan does not require a preauthorization for emergency services.
 - With respect to certain emergency services rendered in the emergency department of an Out-of-Network Hospital, the Plan does not impose a co-payment or Coinsurance that is greater than the co-payment or Coinsurance that would be assessed if the services had been performed in the emergency department of an In-Network Hospital.
 3. Covered Persons are afforded additional rights with respect to internal appeals under the Plan and are provided with the opportunity to undergo a new external review procedure.
 4. The Plan is required to cover certain charges associated with Approved Clinical Trials.
 5. The Plan is generally required to comply with out-of-pocket limits that are established by the federal government and may be adjusted annually.

GENERAL BENEFIT PROVISIONS

In order for the Plan to pay any benefits, all of the following requirements must be met:

- A. An expense must be incurred by a Covered Person while this Plan is effective and the Covered Person participates in the Plan. Unless otherwise provided in the Plan, a Covered Expense, loss, charge, or claim is incurred on the date that services or materials are provided.
- B. The Covered Person must follow the claim procedures of this Plan.
- C. The benefit must be one of the benefits described in this Plan, including all causation limitations, Deductibles, maximum limits and caps, benefit percentages, and any other payment limitations within the benefit.
- D. The expense incurred by a Covered Person must be a Covered Expense payable under a benefit described in the Plan or a charge expressly covered by a benefit in the Plan.
- E. The expense will be paid or reimbursed only to the extent that it is based on either a contracted schedule or on the Plan's Usual and Customary fee limitations and is submitted with appropriate procedural and diagnostic codes for the service(s) rendered.
- F. The expense must not be excluded or in excess of a limitation as provided in the General Plan Exclusions and Limitations section.
- G. The expense must not be payable or reimbursable by another plan whose coverage is primary to the coverage of this Plan, as provided in the Coordination of Benefits section.

If a change in the Covered Person's coverage that would increase or decrease any maximum benefit applicable to the Covered Person becomes effective in accordance with the terms of the Plan, that increase or decrease shall apply immediately.

UTILIZATION OF IN-NETWORK PROVIDERS

The Plan has entered into an agreement with a network of Physicians, Hospitals, and other medical providers (In-Network Providers) who have agreed to provide health care at discounted fees. For Covered Persons who use In-Network Providers, this option works in tandem with the traditional coverage under the Plan by giving those Covered Persons the opportunity to reduce their out-of-pocket expenses. If a Covered Person chooses to be treated by an In-Network Provider, payment of charges for eligible benefits under the Plan will be made at the corresponding percentage stated in the Schedule of Benefits and will be subject to the co-payment(s) stated in the Schedule of Benefits (however, as further explained in the Schedule of Benefits, in no event will a Covered Person be charged an In-Network co-payment if it would

cause him or her to pay more than the Plan's established limits for the amount a Covered Person or Family must pay for all eligible In-Network medical expenses).

Covered Persons will be given the names of Physicians, Hospitals, and other medical providers available in their area who have agreed to be In-Network Providers. The network names are printed on the Covered Person's identification card, and a complete list of In-Network Providers participating in these networks can be viewed by visiting the networks' Website addresses. Covered Persons may also request a complete list of In-Network Providers from the Plan Administrator, which will be provided to Participants as a separate document free of charge.

Medical treatment is solely a decision between a Covered Person and their Physician. While the Plan may provide different levels of benefits depending on the Covered Person's choice of provider, neither the Plan Administrator nor the Claim Administrator endorses one licensed medical provider over another. Increased benefit levels applicable to In-Network Providers are based solely upon negotiated fees or discounts.

If a Covered Person chooses to be treated by an Out-of-Network Provider, services and treatment provided by the Out-of-Network Provider are not eligible under the Plan unless specifically stated otherwise in the Schedule of Benefits.

UTILIZATION REVIEW PROGRAM

MANDATORY HOSPITAL ADMISSION CERTIFICATION

If a Covered Person is scheduled for an Inpatient Hospital confinement, or is admitted to a Hospital on an observation basis, that Hospital stay should be reviewed before the admission.

A Covered Person must call the number on the front of his or her health plan identification card as soon as possible before a Hospital admission, but in no event later than 48 hours following the admission.

MANDATORY OUTPATIENT SERVICE CERTIFICATION

If a Covered Person's treatment includes any of the following services, the treatment should be reviewed before its inception, regardless of whether or not the treatment is in lieu of hospitalization:

- A. Outpatient Physical Therapy
- B. Outpatient Occupational Therapy
- C. Outpatient Speech Therapy
- D. Rental or purchase of Durable Medical Equipment
- E. Home Health Care
- F. Purchase of a custom-made Orthotic or Prosthetic Appliance
- G. Outpatient oncology treatment (chemotherapy or radiation therapy)

A Covered Person must call the number on the front of his or her health plan identification card as soon as possible before receiving the above-listed services, but in no event later than 48 hours after the services were rendered.

ADDITIONAL INFORMATION

Completion of the mandatory certification requirements does not guarantee payment. Payment is subject to the Plan Administrator's determination of eligibility and coverage. If certification is denied, the Covered Person may appeal this decision, as described in the Appeal of Denial subsection of the Claims Procedure section.

ALTERNATIVE TREATMENT

The description of Covered Expenses under the Plan may be expanded in certain situations in order to provide the most appropriate and cost-effective level of care for the Covered Person. These alternative treatment benefits may be provided after review and consultation with both the Utilization Review Firm and the Covered Person's Physician. Each situation shall be reviewed, and recommendations made, on a case-by-case basis. The Utilization Review Firm cannot require a change in a Covered Person's level of care without the approval of the attending Physician. After alternative treatment is initiated, the Utilization Review Firm shall monitor the care to ensure that the most appropriate level of care is maintained. This provision shall not increase any stated maximum benefits described in the Schedule of Benefits.

COMPREHENSIVE MEDICAL EXPENSE BENEFIT

BENEFIT PERCENTAGE AND DEDUCTIBLE

Generally, the Plan will pay the percentage stated in the Schedule of Benefits, except that the Covered Person or Family, not the Plan, must first pay the amounts necessary to satisfy the Deductibles listed in the Schedule of Benefits. However, once the applicable Maximum Out-of-Pocket stated in the Schedule of Benefits has been satisfied, the Plan will then pay 100% of Covered Expenses until the end of the Plan Year.

The Deductibles apply to the Covered Expenses of each Plan Year. An individual Deductible need be satisfied only once per Plan Year, regardless of the number of Illnesses, except that once a Family has exceeded the Family Deductible, any remaining Deductibles for individuals within the Family need no longer be met. In no event shall the maximum Deductible for any one Covered Person exceed the amount stated in the Schedule of Benefits; no individual within a Family will be allowed to satisfy "extra" Deductibles in order to fulfill the Family Deductible.

Charges that were used to satisfy the cash Deductible under any prior plan, or cash Deductibles under any insurance coverage for the Plan Year in which this Plan originally became effective, shall be credited toward satisfying the cash Deductible for this Plan, upon receipt of documented proof of full or partial satisfaction.

ALLOCATION AND APPORTIONMENT OF BENEFITS

The Plan Administrator may allocate the Deductible amount to any eligible charges and apportion the benefits to the Covered Person and any assignees. The allocation and

apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

COVERED CHARGES

In order to be eligible for benefits under this section, services a Covered Person actually receives must be administered or ordered by a Physician and be Medically Necessary for the diagnosis and treatment of an Illness or Injury, unless otherwise specifically covered.

NOTE: Some of the following provisions may conflict to some extent with the preventive care services required by Health Care Reform to be covered under this Plan as a Routine Preventive Care expense. A summary of these required preventive care items and services can be viewed by logging on to the Claim Administrator's Website address printed on the back of the Covered Person's identification card or by calling the Claim Administrator at the telephone number printed on the back of the Covered Person's identification card. In the event a provision below conflicts with the provisions of the summary, the provisions of the summary will rule.

Covered charges include the following:

A. *Abortions*

Charges for Medically Necessary abortions.

B. *Allergy Services*

Charges for allergy services, including injections, serum and testing.

C. *Ambulances*

Charges for professional ambulance service (ground and/or air) to or from a facility where appropriate care or treatment may be rendered or may have been rendered when the Covered Person's condition mandates such transportation.

D. *Anesthesia*

Charges for the cost and administration of an anesthetic by a Physician and/or a Certified Registered Nurse Anesthetist.

E. *Behavioral Care*

Charges for Behavioral Care including services provided by a Physician or by counselors or therapists who are certified or licensed as social workers, Psychologists, or Clinical Nurse Specialists and who have a master's degree or its equivalent in psychology, counseling education/counseling psychology, social work, or psychiatric nursing. Charges rendered by a provider for applied behavioral analysis (ABA) treatment will also be eligible for coverage when a diagnosis of autism has been made by a Physician, a treatment plan for the Covered Person has been developed by a board certified behavioral analyst, and such treatment is performed by a board certified behavioral analyst. Addictions

Treatment care may also be rendered by an Addictions Treatment counselor who is certified and licensed by the state in which he or she practices.

The Covered Person's diagnosis must be specifically classified by reference to the most current version of the International Classification of Diseases published by the U.S. Department of Health and Human Services. If the Covered Person's condition is not considered subject to improvement by generally accepted standards, charges for subsequent evaluation and diagnosis of that condition are not covered.

The care must fall into one of the following categories:

1. Individual psychotherapy
2. Family counseling for members of the Covered Person's Family
3. Group therapy
4. Psychological testing by a Psychologist
5. Electroshock therapy
6. Autism spectrum disorder therapy

Behavioral Care services may be rendered in any combination of the following intensities:

1. Inpatient admission.
2. Partial Hospitalization care (a day program consisting of at least five sessions per day for at least five days per week). A Partial Hospitalization program is an alternative to an Inpatient treatment program. The treatment categories of a Partial Hospitalization treatment program may include treatment categories that are provided in a Physician's office, Outpatient Behavioral Care Facility, Behavioral Care Hospital Outpatient department, or an extension of a Behavioral Care Hospital.
3. Intensive Outpatient care (a day program consisting of fewer than five sessions per day for fewer than five days per week). The treatment categories of an Intensive Outpatient treatment program may include treatment categories that are provided in a Physician's office, Outpatient Behavioral Care Facility, Behavioral Care Hospital Outpatient department, or an extension of a Behavioral Care Hospital.
4. Outpatient therapy (periodic visits ranging from one session per week to one session per month).

Eligible prescription drugs prescribed for Behavioral Care purposes will be covered under the Prescription Drug Benefit. No benefits are provided for treatment of nicotine addiction unless expressly stated elsewhere in the Plan document.

F. Birthing Centers

Charges for services and supplies furnished by a Birthing Center to an eligible Covered Person for prenatal care, delivery, and postpartum care rendered within 24 hours after delivery.

G. Blood Processing

Charges for the processing and administration of blood or blood components, but not for the cost of the actual blood or blood components if replaced.

H. Breast Reconstruction Following Mastectomy

Charges for the following services related to breast reconstruction when performed in conjunction with a mastectomy:

1. Reconstruction of the breast on which the mastectomy has been performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Prostheses.
4. Treatment of physical complications of all stages of mastectomy, including lymphedema.

Coverage will be provided in a manner determined in consultation with the Covered Person and his/her attending Physician.

I. Chiropractic Care

Charges for the services of a Physician who is a chiropractor for the diagnosis and treatment of an Injury or Illness, and for custodial or maintenance care, are covered by this Plan to the extent that these charges do not exceed the benefit maximum(s) stated in the Schedule of Benefits. Eligible chiropractic services are limited to spinal manipulations, therapy treatments, diagnostic spinal X-rays, and office visits (initial and periodic evaluations).

Charges for support pillows, braces, or any other type of equipment recommended or prescribed by a chiropractor are not covered under the Plan. Chiropractic charges are not covered by any other benefit in this Plan.

J. Clinical Trials

Charges for Routine Patient Costs for items and services furnished to a Covered Person who has cancer or a Life-Threatening Condition and who is a Qualified Individual in connection with participation in an Approved Clinical Trial. The Plan will not deny such a Covered Person's participation in an Approved Clinical

Trial or discriminate against such a Covered Person on the basis of his or her participation in an Approved Clinical Trial.

The following definitions apply for purposes of clinical trial coverage under the Plan:

1. The term “Approved Clinical Trial” means a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Condition, as further described in Section 2709(d) of the Public Health Services Act.
2. The term “Life-Threatening Condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted, as described in Section 2709(e) of the Public Health Services Act.
3. The term “Qualified Individual” means 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 other Life-Threatening Condition and where either the referring health care professional is a participating health care provider and has concluded that the individual’s participation in the clinical trial would be appropriate based upon the individual meeting the trial protocol, or the individual provides medical and scientific information establishing that his or her participation in the clinical trial will be appropriate based upon the individual meeting the trial protocol.
4. The term “Routine Patient Costs” means items and services consistent with the Plan’s typical coverage for a Covered Person who is not enrolled in a clinical trial. Routine Patient Costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs of the clinical trial and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

K. Convalescent Care

Charges made by a Convalescent Nursing Facility for the following services and supplies furnished by the facility during a Convalescent Period. Only charges incurred in connection with convalescence from the Illness or Injury for which the Covered Person is confined will be eligible for benefits. These charges include the following:

1. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis, such as general nursing services. However, admittance fees shall not be included in Room and Board and shall not be covered under the Plan. In the event

that the Covered Person chooses a private room when a Semi-Private room is available, the Plan will not cover the additional Room and Board charge.

2. Medical services customarily provided by the Convalescent Nursing Facility. Private duty or special nursing services and Physician's fees are not covered under this benefit, but may be a Covered Expense elsewhere in the Plan.
3. Drugs, biologicals, solutions, dressings, and casts furnished for use during the Convalescent Period, but no other supplies.

L. Diabetes Self-Management Training

Charges incurred for diabetes self-management training, including information on medical nutrition therapy.

M. Diagnosis or Treatment of Underlying Cause of Infertility

Charges for necessary services or fees to diagnose or treat the underlying cause of infertility or sterility. Prescription drugs prescribed for the treatment of infertility are not eligible for Plan coverage.

N. Durable Medical Equipment

Charges for the rental of a wheelchair, hospital bed, iron lung, or other Durable Medical Equipment required for temporary therapeutic use, or the purchase of this equipment if economically justified, whichever is less; charges for maintenance and service necessary for the normal function of Durable Medical Equipment that has been purchased (but not for that which is being rented).

Modifications to houses or vehicles, including, but not limited to, platform lifts, stair lifts, stairway elevators, wheelchair lifts or ramps, and ceiling lifts are not considered Durable Medical Equipment and are not covered under the Plan.

O. Home Health Care

Charges for the following home health care services and supplies, including those provided by a Home Health Care Agency:

1. Registered Nurses or Licensed Practical Nurses.
2. Certified home health aides if Medically Necessary.
3. Licensed therapists performing Physical Therapy, Occupational Therapy, Speech Therapy, or psychosocial therapy.
4. Physician calls in the office, home, clinic, or Outpatient department.

5. Medications, services, and medical supplies ordered by a Physician necessary for the treatment of the Covered Person, but not including meals normally prepared in the home.
6. Rental of Durable Medical Equipment and, if approved by the Plan Administrator in advance, purchase of that equipment.
7. Transportation to and from Physician, therapist, Outpatient facility, Hospital, or other provider of treatment, including an ambulance (where the patient's condition mandates that utilization), ambulance (if the diagnosis makes automobile travel unsuitable), licensed taxicab, or mileage for a driver approved by the Plan.

P. Hospice Charges

Charges made by a Hospice during a Hospice Benefit Period for the following:

1. Nursing care by a Registered Nurse or a Licensed Practical Nurse, vocational nurse, or public health nurse who is under the direct supervision of a Registered Nurse.
2. Licensed therapists performing Physical Therapy, Occupational Therapy, Speech Therapy, or psychosocial therapy.
3. Medical supplies, including drugs and biologicals, and the use of medical appliances.
4. Physician's services.
5. Services, supplies, and treatments deemed Medically Necessary and ordered by a Physician.

Q. Hospital Charges

Charges made by a Hospital for the following:

1. Daily Room and Board and general nursing services or confinement in an Intensive Care Unit, including nursery charges for a Newborn Dependent. In the event that the Covered Person chooses a private room when a Semi-Private room is available, the Plan will not cover the additional Room and Board charge.
2. Necessary services and supplies other than Room and Board furnished by the Hospital, including Inpatient miscellaneous service and supplies, Outpatient Hospital treatments for chronic conditions and emergency room use, Physical or Occupational Therapy treatments, hemodialysis, and X-ray therapy. Charges incurred for miscellaneous services and supplies by a Newborn Dependent will be covered.

NOTE: The Plan may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to fewer than 48 hours following a normal vaginal delivery, or fewer than 96 hours following a cesarean section. However, pursuant to federal law, the Plan generally does not prohibit the mother's or Newborn's attending provider, after consulting with the mother, from discharging the mother or Newborn earlier than 48 hours (or 96 hours, as applicable). In any case, the Plan may not require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

R. Laboratory

Charges for microscopic tests and laboratory tests.

S. Loss-Control Services

Approved fees for loss-control services such as fee negotiations, claim reviews, and fraud and abuse audits.

T. Medical Supplies

Charges for dressings, casts, splints, trusses, braces, or other necessary medical supplies, with the exception of orthodontic braces or corrective shoes.

U. Newborn Care

Charges for the usual, ordinary, and Routine care of a Newborn.

V. Nicotine Abuse Treatment

Charges for the treatment of nicotine abuse.

W. Nurse-Midwives

Charges for a fully certified or licensed and insured Nurse-Midwife. Delivery must occur within a Hospital or Birthing Center with an OB/GYN Physician present in the facility. The Nurse-Midwife must have a formal written agreement with a Physician who is a specialist in obstetrics and gynecology for OB consultation and referral services.

X. Nursing

Fees of Registered Nurses or Licensed Practical Nurses for short-term, intermittent, and transitional private duty nursing care.

Y. Obesity Treatment

Charges for Medically Necessary, non-surgical treatment of Obesity are covered when a diagnosis of Morbid Obesity is given and a co-morbid condition is present that is aggravated by Morbid Obesity. Charges from diet centers including, but

not limited to, the cost of food and food supplements, are not considered Covered Expenses.

No benefits are payable for any surgical procedure performed for the treatment of Obesity or for the purpose of weight reduction. However, the Plan will cover treatment of complications arising during or subsequent to such a surgical procedure.

Z. Obstetrics

Physician's charges for obstetrical services are paid on the same basis as for an Illness, including charges for the initial examination of a Newborn by a Physician, and the mother's prenatal care. Benefits are provided for a Pregnancy of a Dependent child.

AA. Oral Surgery; Illness- and Accident-Related Dental Treatment

Charges incurred for the following:

1. An alveolectomy, a gingivectomy, or a vestibuloplasty, or for the removal of impacted or partially impacted teeth (no allowance for other extractions) on an Outpatient basis, or, if deemed to be Medically Necessary by the attending Physician, on an Inpatient basis. However, if the Employer's dental policy, if any, considers an oral surgery to be eligible for coverage under that plan/policy, this Plan will deem that oral surgical procedure and any associated charges to not be eligible under this benefit or any other benefit of the Plan.
2. Treatment (excluding dentures and implants) required because of an Illness or Accidental bodily Injury to natural teeth. Expenses related to an Accident must be incurred within six months of the date of the Accident. Dental services that are typically preventive in nature, such as oral examinations, cleanings, and X-rays, are not eligible under this benefit unless Medically Necessary for the treatment of the Injury or Illness.

BB. Orthoptics/Vision Therapy

Charges for Medically Necessary Orthoptics or Vision Therapy when diagnosed and/or administered by a provider who is duly licensed by the state to perform such services.

CC. Orthotic or Prosthetic Appliances

Charges for Orthotic or Prosthetic Appliances or artificial limbs, eyes, or larynges, but not the replacement of these unless the current Orthotic or Prosthetic Appliance or artificial limb, eye, or larynx is not functional.

DD. Oxygen and Other Gases

Charges for oxygen and other gases and their administration.

EE. Physical/Occupational Therapy

Treatment or services rendered by a licensed physical therapist or a licensed occupational therapist for Physical or Occupational Therapy in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury.

FF. Physician Services

The services of a Physician for medical care including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care, surgical procedures to diagnose and treat Injuries and Illnesses, and surgical opinion consultations, unless specifically stated as a Covered Expense elsewhere in the Plan.

GG. Radiation Therapy and Chemotherapy

Charges for radiation therapy and treatment and for chemotherapy and treatment.

HH. Routine Preventive Care

Charges for Routine preventive care for Covered Persons, including, but not limited to, examinations and items and services listed in the following four categories are eligible under this benefit, as described in the Schedule of Benefits:

1. Items and services rated “A” or “B” by the U.S. Preventive Services Task Force, including screenings for high blood pressure, cervical cancer, cholesterol abnormalities, colorectal cancer, depression, diabetes, hearing loss, hemoglobinopathies (Sickle Cell Disease), hepatitis B, HIV, and osteoporosis; screenings and counseling to reduce alcohol misuse; screenings and counseling for Obesity treatment; counseling for a healthy diet; and counseling for tobacco use.
2. Immunizations, including those immunizations recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention for children and adults.
3. Preventive care and screenings for children as recommended by the Health Resources and Services Administration.
4. Preventive care and screenings for women as recommended by the Health Resources and Services Administration.

A list of covered preventive care items and services can be viewed by logging on to the Claim Administrator’s Website address printed on the back of the Covered

Person's identification card or by calling the Claim Administrator at the telephone number printed on the back of the Covered Person's identification card (alternatively, see the Other Basic Information About the Plan section).

II. Speech Therapy

Fees of a legally qualified Physician or qualified speech therapist for restorative or rehabilitative Speech Therapy for speech loss or impairment caused by an Illness or Injury (other than a Functional Nervous Disorder), or caused by surgery performed because of an Illness or Injury. If the speech loss or impairment is caused by a congenital anomaly, surgery to correct the anomaly must have been performed before the therapy.

JJ. Temporomandibular Joint Dysfunction Services

Charges for the diagnosis and treatment of temporomandibular joint dysfunction that are deemed to be eligible are payable the same as any other Illness; that is, cost-sharing provisions such as Deductibles, Coinsurance, or co-payments may apply depending upon the type of service rendered. The Plan will also allow charges for surgery if all other means of generally accepted treatment have been exhausted.

Charges for orthodontic braces are not covered under this benefit.

KK. Transplants

Services and supplies in connection with organ and/or tissue transplant procedures, subject to the following conditions:

1. The Plan Administrator may require additional information from Physicians to determine if benefits are excluded owing to the experimental or investigational nature of some transplant procedures or are otherwise excluded under the Plan. The Plan Administrator may require the Covered Person to obtain a second opinion on whether the transplant procedure is Medically Necessary. A second opinion will be in accordance with the Second Surgical Opinion Benefit, if any.
2. If the donor is a Covered Person under this Plan but the recipient is not, the donor's Covered Expenses will be considered under this benefit on a secondary basis to the recipient's plan.
3. If the recipient is a Covered Person under this Plan, the recipient's Covered Expenses are covered under this benefit.
4. If the donor is not a Covered Person under this Plan but the recipient is, the donor's expenses will be covered under this benefit on a secondary basis to the donor's plan if the expenses are Covered Expenses (had the expenses been incurred by a Covered Person).

Benefits paid to or on behalf of the donor by this paragraph are treated as though they were paid to the recipient for purposes of Deductibles, payment percentages, Plan maximums, etc.

5. Covered Expenses include the cost of securing an organ from a cadaver or tissue bank, the surgeon's charge for removal of the organ, a Hospital's charge for storage or transportation of the organ, and charges for travel (including lodging, transportation, and meals at the health care facility providing treatment) that qualify under Section 213 of the Code and have been pre-authorized by the Plan Administrator.

LL. Voluntary Sterilizations

Charges for voluntary sterilization of Participants and Dependent spouses.

MM. X-rays

Charges for X-rays.

PRESCRIPTION DRUG BENEFIT

PRESCRIPTION DRUG CARD PROGRAM

Charges are covered under this benefit for eligible drugs that are prescribed in writing by a Physician, Physician's Assistant, or Nurse Practitioner within the legally appointed scope of his/her license. Benefits are paid in excess of the co-payment per prescription listed in the Schedule of Benefits. The Plan Administrator may establish other procedures to administer this benefit. If the Plan Administrator issues prescription identification cards, all Covered Persons are required to return these cards immediately when coverage ceases. The Plan will allow the Covered Person to fill a prescription for up to and including a 90-day supply, subject to the Prescription Agreement between the Employer and the Pharmacy Benefits Manager (PBM).

If an eligible prescription is filled at a pharmacy within the designated network, the Covered Person will be responsible only for the co-payment amount when purchasing the drug. If an eligible prescription is a) purchased at a pharmacy that is not within the designated network, or b) purchased at a pharmacy within the designated network without showing the proper coverage identification card, the Covered Person must pay the purchase price in full and then must submit the expense, with a completed prescription drug reimbursement claim form (available at the Employer or from ASR), directly to the PBM for processing.

Claims for prescription drugs must include the name of the prescribed medication, the patient's full name, the date that services were rendered or purchases made, and the cost per item. Reimbursement will be made to you based on a formula determined by the PBM and agreed to by the Employer. The amount you receive may be less than the difference between the purchase price and the co-payment amount.

MAIL SERVICE PROGRAM

Charges are covered under this benefit for eligible drugs that are provided through the Mail Service Program and that are prescribed in writing by a Physician, Physician's Assistant, or Nurse Practitioner within the legally appointed scope of his/her license. Each prescription purchase is subject to the co-payment stated in the Schedule of Benefits. The Mail Service Program is specifically designed to provide the Covered Person with maintenance drugs for up to and including a 90-day supply.

SPECIALTY PHARMACY PROGRAM

Charges are generally covered under this benefit for eligible drugs on the specialty drug list maintained by the PBM that are prescribed in writing by a Physician, Physician's Assistant, or Nurse Practitioner within the legally appointed scope of his/her license. However, special rules may apply in order for such drugs to be covered. Covered Persons prescribed a specialty prescription drug should contact the PBM at the number on the identification card to learn about the special rules that may apply to the drug, including the co-payment that will be charged or other special coverage terms that will apply. Specialty drugs may be certain injectable medications, high-cost medications, or have special delivery or storage requirements (e.g., they may require refrigeration). Covered Persons may generally fill a prescription for a specialty prescription drug for up to and including a 30-day supply, subject to the Prescription Agreement between the Employer and the PBM. Contact the PBM for more information about this program.

COVERED PRODUCTS

- ♦ Anti-diabetic injectables (e.g., Byetta)
- ♦ Compounded medications
- ♦ Contraceptives (all FDA-approved methods designated as covered by the PBM, including emergency kits, but excluding abortifacient agents)
- ♦ Diabetic pen needles
- ♦ Disposable diabetic blood/urine glucose/acetone testing agents
- ♦ Disposable diabetic needles and syringes
- ♦ Federal legend drugs (unless specifically listed as an Excluded Product below)
- ♦ Flu shots and other routine vaccines / immunizations designated as covered by the PBM (\$-0-co-payment applies)
- ♦ Glucagon emergency kit
- ♦ Growth hormones
- ♦ Human Immunodeficiency Virus (HIV) drugs
- ♦ Injectables, self-administered (unless specifically listed as an Excluded Product below)
- ♦ Insulin
- ♦ Lancet devices
- ♦ Lancets
- ♦ Low molecular weight heparins (e.g., Lovenox)
- ♦ Oral immunosuppressives
- ♦ Over-the-counter forms of proton pump inhibitor drugs and non-sedating antihistamine drugs (Physician's prescription is required)
- ♦ Sexual dysfunction agents
- ♦ Smoking cessation products

COVERED PRODUCTS, cont.

- ♦ Specialty medications designated as covered by the PBM (oral and injectable forms)
- ♦ Vitamins, prescription or prenatal

EXCLUDED PRODUCTS

- ♦ Alcohol swabs
- ♦ Allergens
- ♦ Blood products
- ♦ Control solution
- ♦ Cosmetic drugs (unless specifically listed as a Covered Product above)
- ♦ Dental fluorides
- ♦ Diagnostic agents
- ♦ General anesthetics
- ♦ Glucose monitors
- ♦ Immunizations / vaccines (unless specifically listed as a Covered Product above)
- ♦ Infertility drugs
- ♦ Injectables, office-based (unless specifically listed as a Covered Product above)
- ♦ Medical devices or appliances (unless specifically listed as a Covered Product above)
- ♦ Nutritional supplements
- ♦ Over-the-counter products, including vitamins (unless specifically listed as a Covered Product above)
- ♦ Weight loss medications

NOTES:

1. In accordance with the requirements of Health Care Reform, the Plan provides coverage for certain preventive care medications without any cost-sharing provisions such as Deductibles or co-payments. For more information about eligible preventive care medications, Covered Persons can contact the PBM at the number on the front of the identification card. In the event a conflict arises between this provision and the information stated under the Excluded Products subsection above, the terms of this provision will rule.

2. Quantity limits or a prior authorization requirement may apply to some drugs. To obtain more information about the Plan's prescription drug benefit, including information about the coverage status or the co-payment amount applicable to a particular drug, the Covered Person can call the PBM's phone number listed on the front of his or her identification card.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS
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NOTE: Some of the following exclusions may conflict to some extent with the preventive care services required by Health Care Reform to be covered under this Plan as a Routine Preventive Care expense. A summary of these required preventive care items and services can be viewed by logging on to the Claim Administrator's Website address printed on the back of the Covered Person's identification card or by calling the Claim Administrator at the telephone number

printed on the back of the Covered Person's identification card. In the event an exclusion below conflicts with the provisions of the summary, the provisions of the summary will rule.

The following exclusions and limitations apply to expenses incurred by all Covered Persons and to all benefits provided by this Plan. No benefits shall be payable by the Plan for the following items:

A. Acupuncture; Acupressure

Charges for acupuncture or acupressure.

B. Charges Not Medically Necessary, Above Usual and Customary, or Not Physician Recommended or Approved

Unless specifically shown as a Covered Expense elsewhere in the Plan, charges that meet any of the following criteria:

1. Are incurred in connection with services and supplies that are not Medically Necessary for treatment of an Injury or Illness.
2. Are in excess of Usual and Customary charges.
3. Are not in compliance with generally accepted billing practices for unbundling or multiple procedures.
4. Are not recommended and approved by a Physician.

C. Completion of Claim Forms

Charges incurred for completion of insurance or benefit payment claim forms.

D. Correctional Institutions

Charges resulting from, or in connection with, a Covered Person while the Covered Person is confined in a penal or correctional institution.

E. Cosmetic Procedures

Charges incurred in connection with the care, treatment, or surgery performed for a Cosmetic Procedure. This exclusion shall not apply to procedures necessary to lessen or correct a deformity arising from, or directly related to, a congenital abnormality, a personal Injury resulting from an Accident or trauma, or a disfiguring disease for a Covered Person. The Plan does not cover replacement of breast implants that were initially considered to be for cosmetic purposes and were not Medically Necessary.

F. Dental

Charges incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue, or a molar process, and any other dental, orthodontic, or oral surgical charges, unless expressly included in a benefit of this Plan.

G. Effective Date of Coverage

Charges incurred before a Covered Person's effective date of coverage under the Plan, or after coverage and any extensions of participation are terminated.

H. Elective Abortions

Charges for elective abortions.

I. Experimental; Investigational

Charges for services or supplies that are Experimental or Investigational in nature.

J. Fees and Taxes

Charges for sales tax, processing fees, fees for the attainment of medical records, and the like.

K. Free School-Provided Special Education Services

Charges for services provided for physically and/or mentally impaired individuals where a school is required to provide those services free of charge (e.g., special education).

L. Illegal Acts

Charges incurred for an Illness or Injury resulting from or occurring during the commission of a violation of law by the Covered Person, including, but not limited to, the engaging in an illegal occupation or act, the commission of an assault or battery, or the operation of a Motor Vehicle while the Covered Person is under the influence of alcohol or illegal drugs, but excluding minor, non-criminal traffic violations and similar civil infractions.

M. Infertility

Unless expressly included in a benefit of this Plan, charges related to or in connection with all infertility or sterility testing or treatment, procedures to restore or enhance fertility, or any artificial means to achieve Pregnancy or ovulation, including, but not limited to, the following: (1) artificial insemination; (2) in-vitro fertilization; (3) induced ovarian hyperstimulation; (4) gamete intrafallopian transfer (GIFT); (5) zygote intrafallopian transfer (ZIFT); (6) tubal ovum transfer; (7) embryonic freezing, transfer, or implantation procedures; or (8) sperm banking.

N. Infertility Drugs

Charges for prescription drugs prescribed for the treatment of infertility.

O. Legal Obligation to Pay Charges

Charges incurred for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.

P. Missed Appointments

Charges for failure to keep an appointment.

Q. Non-Accepted Treatment and Procedures Not Medically Necessary

Charges for services, supplies, or treatments that the medical community does not recognize as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury, or charges for procedures, surgical or otherwise, that the medical community specifically lists as having no medical value. This exclusion does not apply to Routine preventive care expressly covered by the Plan.

R. Non-Human Treatment

Charges for non-human organ transplants, cloning, or xenografts. However, this exclusion will not apply if the procedure is Medically Necessary, is not Experimental or Investigational, and is commonly and customarily recognized throughout the Physician's profession as appropriate in treating the diagnosed Illness or Injury.

S. Non-Medical Services, Supplies, Etc.

Charges incurred for services or supplies that constitute personal comfort or beautification items; television or telephone use; or Custodial Care, education or training, or expenses actually incurred by other persons.

T. Non-Professional Nursing Services

Charges for professional nursing services if rendered by other than a Registered Nurse or Licensed Practical Nurse, unless that care was vital as a safeguard of the Covered Person's life, or unless that care is specifically listed as a Covered Expense elsewhere in the Plan.

U. Over-the-Counter Products

Charges for all over-the-counter products, even though prescribed by a Physician, Physician's Assistant, or Nurse Practitioner, unless specifically stated as a Covered Expense elsewhere in the Plan.

V. Physician Not Present

Charges for Physicians' fees for any treatment that is not rendered by or in the physical presence of a Physician, except as provided elsewhere in the Plan (e.g., Physician's Assistant, Nurse Practitioner).

W. Provider Related to Covered Person

Charges for services rendered by a Physician, nurse, licensed therapist, or Home Health Care Agency employee to a Covered Person if the individual rendering services is the Covered Person or a Close Relative of the Covered Person or resides in the same household as the Covered Person.

X. Rest Care or Treatment Not Connected With Injury or Illness

Charges for hospitalization when the confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or hospitalization for any Routine physical examinations or tests not connected with the actual Illness or Injury.

Y. Reversal of Sterilization

Charges resulting from, or in connection with, the reversal of a sterilization procedure.

Z. Sexual Transformations, Implants

Charges for treatment for sex transformations or gender reassignments and treatment for inorganic sexual dysfunction or inadequacy that includes implants and related hormone treatment. Charges for individual psychotherapy, group therapy; psychological testing by a Psychologist, and electroshock therapy for the treatment of a Mental Illness or Disorder, excluding sexual transformations or gender reassignments, are not subject to this exclusion and will be considered as Covered Expenses under the Behavioral Care Benefit, if any.

AA. Surgical Treatment of Obesity/Weight Reduction

Charges for any surgical procedure performed for the treatment of Obesity or for the purpose of weight reduction.

BB. Surrogate Pregnancy

Charges incurred for actual or attempted impregnation or fertilization by any means involving a surrogate donor or surrogate recipient. Charges incurred involving a surrogate Pregnancy.

CC. Travel to Foreign Countries for Specific Treatment

Charges incurred outside the United States if the Covered Person traveled to such a location for the primary purpose of obtaining medical services, drugs, or supplies. This exclusion does not apply if the location was closer to, or substantially more accessible from, the Covered Person's residence (or if an emergency exists, the place where the Covered Person suffered the Illness or Injury) than the nearest location within the United States that was adequately equipped to deal with, and was available for the treatment of, the Covered Person's Illness or Injury.

DD. Vision; Hearing

Charges incurred in connection with eye refractions or the purchase or fitting of eyeglasses, contact lenses, or hearing aids. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery, nor does it apply to the initial purchase of a hearing aid if the loss of hearing is a result of a surgical procedure performed while coverage is in effect. This exclusion does not apply to benefits expressly provided by a Vision Benefit or Hearing Benefit, if any. Charges incurred for or relating to radial keratotomy or keratectomy or similar procedures are excluded under this Plan.

EE. War or Armed Forces Service

Charges caused as a result of war or any act of war, whether declared or undeclared, if incurred during service (including part-time service and national guard service) in the armed forces of any country.

FF. Weekend Hospital Admittance

Charges for Room and Board incurred in connection with a Hospital admittance on Friday, Saturday, or Sunday, unless significant medical treatment is given on those days. Significant medical treatment includes any treatment not normally connected with Room and Board or general nursing services.

GG. Work-Related

Charges for the treatment of an Injury or Illness that arose out of or in the course of any employment or occupation for wage or profit for which the Covered Person is eligible for benefits or claims or has claimed to be eligible for benefits under any workers' compensation or occupational disease law, or any similar law, whether or not he or she has applied for these benefits.

NOTE: These exclusions will not apply to the extent they would violate the Americans With Disabilities Act or any other applicable law. Further, these exclusions will not apply to the extent a court or other judicial body requires the Plan to provide coverage.

ELIGIBILITY AND PARTICIPATION

SCHEDULE FOR ELIGIBILITY AND PARTICIPATION

PARTICIPANT ELIGIBILITY REQUIREMENTS: FULL-TIME EMPLOYEES

In order to be eligible to participate in this Plan, an individual designated by the Employer as a full-time Employee must satisfy the following requirements:

- A. Be currently employed by the Employer in Full-Time Employment for 30 or more hours per week.
- B. Have been employed in Full-Time Employment by the Employer for the previous 30 days.

NOTES:

1. An individual who is eligible to participate in the Plan as both a Participant and a Dependent may enroll as a Participant or as a Dependent, but not as both.
2. If a leased employee is hired by the Employer as a full-time Employee the individual's service for the Employer as a leased employee will be considered when applying the Plan's waiting period.
3. Coverage under the Plan will be provided on a "no loss, no gain" basis to an Employee who transfers employment from one participating Employer to another as identified in the Plan document's Employer definition. This provision will only apply if the Plan Administrator deems the transfer of employment to be without interruption.

PARTICIPANT ELIGIBILITY REQUIREMENTS: SPECIAL RULES FOR ALL EMPLOYEES

As permitted under Health Care Reform, the Employer will use the Measurement Period/Stability Period Safe Harbor method to determine the eligibility of an Employee to participate in the Plan. Employees who work in Full-Time Employment, as described in the immediately preceding section, may automatically be counted as a full-time Employee for the duration of the Employer's established Standard Measurement Period/Standard Stability Period cycle. Alternatively, an Employer can choose to monitor full-time Employees during the Standard Measurement Period/Standard Stability Period cycle as described below. However, all other Employees who are not classified by the Employer as working in Full-Time Employment (non-full-time Employees) will be subject to a special Initial Measurement Period/Initial Stability Period as well as the Employer's established Standard Measurement Period/Standard Stability Period cycle.

A newly hired non-full-time Employee's schedule will be monitored over the course of a 12-month Initial Measurement Period that will begin on the first of the month following the Employee's hire date. Immediately following the end of the Initial Measurement Period, there will be a one-month Initial Administrative Period during which the Employer will evaluate the results of the monitoring and conduct other administrative tasks. If the results show that the non-

full-time Employee averaged 30 or more hours per week over the course of the Initial Measurement Period, the Employee will be considered a full-time Employee eligible for Participant Coverage during a 12-month Initial Stability Period that begins immediately after the expiration of the Initial Administrative Period (qualifying non-full-time Employee). Barring any event that would cause it to terminate, Participant Coverage will remain in effect for a qualifying non-full-time Employee during the entire Initial Stability Period even if the qualifying non-full-time Employee averages fewer than 30 hours per week during that time.

If a non-full-time Employee transfers to Full-Time Employment during the Initial Measurement Period, the Employee will be eligible for Participant Coverage no later than the first day of the fourth month following the change in employment status (in accordance with the terms described in the Participant Eligibility Requirements for full-time Employees section), or if earlier, on the first day of the first month following the end of the Initial Measurement Period (including any Initial Administrative Period).

On an ongoing basis, Employees' schedules, which may include full-time Employees, will be monitored over the course of a 12-month Standard Measurement Period that will begin on June 1. For newly hired non-full-time Employees, this period will count concurrently as some or all of the Initial Measurement Period. Immediately following the end of the Standard Measurement Period, there will be a three-month Standard Administrative Period during which the Employer will evaluate the results of the monitoring and conduct enrollment-related administrative tasks. This Standard Administrative Period will run concurrently with all or part of the Plan's Annual Open Enrollment Period. If the results show that the Employee averaged 30 or more hours per week over the course of the Standard Measurement Period, he or she will be eligible for Participant Coverage during a 12-month Standard Stability Period that will begin on September 1 immediately after the expiration of the Standard Administrative Period. The Standard Stability Period will be the same as the 12-month period for Annual Open Enrollment Elections. The cycle of consecutive Standard Measurement, Administrative, and Stability Periods will continuously repeat.

If a full-time Employee transfers to a non-full-time position before completing the first Standard Measurement Period beginning on or after the Employee's date of hire, the Employee may be subject to a Monthly Measurement Period and the Employee's continued eligibility for each month before the first day of the first Standard Stability Period beginning after the completion of the first Standard Measurement Period may be contingent on the Employee being credited with at least 130 hours of service for that month.

If during an Initial or Standard Measurement Period an Employee (includes all Employees, full-time or otherwise classified) experiences a break of 26 or more consecutive weeks during which he or she is not credited for any hours of service (for this purpose, hours of service includes paid time off and unpaid time off consisting of an FMLA or USERRA leave or jury duty), any time applied to the Measurement Period before the break will be lost and the Employee will be treated as a new hire upon return for purposes of the Measurement Period rules. In addition, if during the Initial Measurement Period the Employee experiences a break of at least four but fewer than 26 consecutive weeks during which he or she is not credited for any hours of service, any time applied to the Measurement Period before the break will be lost if the break lasted longer than the period of credited service that immediately preceded it. A break of fewer than four weeks, or a break of at least four but fewer than 26 consecutive weeks that was shorter than the period of

credited employment that preceded it, will have no effect. An Employee who was enrolled for Participant Coverage before the break in service that does not exceed 26 consecutive weeks (or as otherwise allowed for above) whose coverage was terminated as a result of the break will be eligible to re-enroll as soon as administratively feasible (generally no later than the first day of the month after the Employee's return to work).

NOTE: An individual who is eligible to participate in the Plan as both a Participant and a Dependent may enroll as a Participant or as a Dependent, but not as both.

PARTICIPANT EFFECTIVE DATE

Participation in the Plan will start for new applicants on the first of the month following the date on which they meet the Participant Eligibility Requirements stated above and meet the requirements described in the Participant Enrollment section below.

EMPLOYER-PROVIDED EXTENSIONS OF PARTICIPATION

NOTE: An Employer-provided extension of participation (except to the extent that it is also a Family and Medical Leave Act of 1993 [FMLA] extension of participation) will be offset against the length of a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, extension of participation.

Medical Leave Extension of Participation..... 30 days

Extension of Dependent Participation Following Participant's Death..... 30 days

Additional information regarding Extensions of Participation is provided on page 66.

ANNUAL OPEN ENROLLMENT PERIOD..... In June, July, and/or August

Additional information regarding the Annual Open Enrollment Period is provided on page 64.

REINSTATEMENT..... Unavailable

RETIREE COVERAGE Unavailable

INITIAL REQUIREMENTS

PARTICIPANT ELIGIBILITY

A person is eligible for Participant Coverage under the Plan if the person meets all of the Participant eligibility requirements listed in the Schedule for Eligibility and Participation.

PARTICIPANT ENROLLMENT

A person who was enrolled for Participant Coverage immediately before the effective date of this amended and restated Plan shall be immediately eligible for and can maintain his or her enrollment in Participant Coverage as of the Plan document's effective date if any required

written application has been made. For every other person, Participant Coverage begins on the first of the month following the date on which the person meets both of the following requirements:

- A. The person is eligible for Participant Coverage.
- B. The person has made written application for Participant Coverage on a form acceptable to the Plan Administrator on or before the first date on which coverage could begin.

If application for Participant Coverage is made after the first date on which coverage could begin, but within 30 days after that date, coverage will be retroactive to the first date on which coverage could have begun.

If application for Participant Coverage is not made within 30 days after the date coverage could have begun, the applicant must wait until the Annual Open Enrollment Period unless the applicant has special enrollment rights to enroll during a Special Enrollment Period. An applicant has special enrollment rights to enroll during a Special Enrollment Period in the following circumstances:

- A. The applicant declined coverage when initially eligible or during a subsequent Annual Open Enrollment Period because the applicant had coverage under another group health plan or health insurance coverage, and that other coverage was subsequently lost for one of the following reasons:
 - 1. The other coverage was COBRA, and it has been exhausted.
 - 2. The applicant became ineligible (i.e., as a result of a Change in Status).
 - 3. Employer contributions for the coverage have been terminated.
 - 4. The other coverage was an HMO, and the individual no longer lives or works in the service area of the HMO (whether or not by choice of the individual).
 - 5. The other coverage no longer offers any benefits to a class of similarly situated individuals (e.g., part-time employees).
 - 6. A benefit package option is terminated (unless the individual is provided a current right to enroll in alternative health coverage).
 - 7. A plan's lifetime limit on all benefits was applied.

Proof that the other coverage was lost must be provided to the Plan Administrator upon request.

An individual who lost other coverage on account of nonpayment of the required contribution or for cause (e.g., filing fraudulent claims) shall not have special enrollment rights to enroll during a Special Enrollment Period. An individual

who voluntarily terminates other coverage shall not be considered to have special enrollment rights.

- B. The applicant has acquired a new Dependent by marriage, birth, adoption, or placement for adoption. In this situation, special enrollment rights are available to the Employee, the Employee's spouse, and any child who became a Dependent on account of the marriage, birth, adoption, or placement for adoption.
- C. The applicant's coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is terminated as a result of the applicant's loss of eligibility for Medicaid or the CHIP, or the applicant becomes eligible for a premium assistance subsidy under Medicaid or a CHIP to obtain coverage under this Plan.

An applicant with special enrollment rights must make application for Participant Coverage during the Special Enrollment Period, which is generally during the first 30 days after the loss of other coverage or marriage, birth, adoption, or placement for adoption (whichever is applicable). However, if the loss of other coverage was caused by the application of the plan's lifetime limit on all benefits, the Special Enrollment Period will occur during the 30-day period immediately following the first date on which a claim was denied for that reason. Further, in the case of the loss of Medicaid or CHIP eligibility or the gain of eligibility for a Medicaid or CHIP premium assistance subsidy, the Special Enrollment Period is during the first 60 days after the loss or gain of eligibility. Participant Coverage shall be effective as of the date of the loss of other coverage, the marriage, birth, adoption or placement for adoption, the loss of Medicaid or CHIP eligibility, or the gain of eligibility for a Medicaid or CHIP premium assistance subsidy.

An applicant with special enrollment rights who fails to make application for Participant Coverage during the Special Enrollment Period must wait until the next Annual Open Enrollment Period or until special enrollment rights again apply, whichever occurs first.

All Participant Coverage under the Plan shall begin at 12:01 a.m. local time on the date on which coverage is to begin.

DEPENDENT ELIGIBILITY

A person is eligible for Dependent Coverage under the Plan when both of the following requirements are met:

- A. The person is a Dependent.
- B. The Participant on whom the person is dependent is eligible for Participant Coverage.

DEPENDENT ENROLLMENT

A person who was enrolled for Dependent Coverage immediately before the effective date of this amended and restated Plan shall be immediately eligible for and can maintain his or her enrollment in Dependent Coverage as of the Plan document's effective date if any required written application has been made and he or she satisfies all of the requirements in the

Dependent Eligibility section. For every other person, Dependent Coverage begins when all of the following requirements are met:

- A. The person is eligible for Dependent Coverage.
- B. The Participant on whom the person is dependent is a Covered Person.
- C. The Participant makes a written application for Dependent Coverage on a form acceptable to the Plan Administrator on or before the first date that coverage could begin. This requirement does not apply to newly acquired Dependents by marriage, birth, or court order or decree (e.g., adoption or during the placement of the Dependent for adoption). For these Dependents, see the next paragraph below.

Notwithstanding the immediately preceding paragraph, the following special rules apply to newly acquired Dependents by marriage, birth, or court order or decree (e.g., adoption or during the placement of the Dependent for adoption):

- 1. A Participant's spouse may be enrolled as a Dependent as of the date of marriage if written application for Dependent Coverage for the spouse is made within 30 days of the date of marriage.
- 2. A Participant's Newborn will be covered from the moment of birth for Injury or Illness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, if written application for Dependent Coverage for the child is made within 30 days of the child's date of birth. The provision shall not apply to, nor in any way affect, the maternity provisions of this Plan, if any, applicable to the mother.
- 3. If a Dependent is acquired other than at the time of the Dependent's birth on account of marriage, or a court order or decree, that Dependent may be enrolled as a Dependent as of the date of the marriage, court order or decree, if written application for Dependent Coverage for the new Dependent is made within 30 days of the court order, decree, or marriage. Dependent Coverage for a child to be placed with a Participant through adoption is effective as of the date the child is placed for adoption, if written application for Dependent Coverage for the child is made within 30 days of the child's placement. A child is considered placed for adoption if the Participant has a legal obligation for total or partial support of the child in anticipation of the child's adoption.

If application for Dependent Coverage is not made within 30 days after the date coverage could have begun, the applicant must wait until the Annual Open Enrollment Period unless the applicant has special enrollment rights to enroll during a Special Enrollment Period. An applicant has special enrollment rights to enroll during a Special Enrollment Period in the following circumstances:

1. The applicant declined coverage when initially eligible or during a subsequent Annual Open Enrollment Period because the applicant had coverage under another group health plan or health insurance coverage, and that other coverage was subsequently lost for one of the following reasons:
 - a. The other coverage was COBRA, and it has been exhausted.
 - b. The applicant became ineligible (i.e., as a result of a Change in Status).
 - c. Employer contributions for the coverage have been terminated.
 - d. The other coverage was an HMO, and the individual no longer lives or works in the service area of the HMO (whether or not by choice of the individual).
 - e. The other coverage no longer offers any benefits to a class of similarly situated individuals (e.g., part-time employees).
 - f. A benefit package option is terminated (unless the individual is provided a current right to enroll in alternative health coverage).
 - g. A plan's lifetime limit on all benefits was applied.

Proof that the other coverage was lost must be provided to the Plan Administrator upon request.

An individual who lost other coverage on account of nonpayment of the required contribution or for cause (e.g., filing fraudulent claims) shall not have special enrollment rights to enroll during a Special Enrollment Period. An individual who voluntarily terminates other coverage shall not be considered to have special enrollment rights.

2. The applicant has acquired a new Dependent by marriage, birth, adoption, or placement for adoption. In this situation, special enrollment rights are available to the Employee, the Employee's spouse, and any child who became a Dependent on account of the marriage, birth, adoption, or placement for adoption.
3. The applicant's coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is terminated as a result of the applicant's loss of eligibility for Medicaid or the CHIP, or the applicant becomes eligible

for a premium assistance subsidy under Medicaid or a CHIP to obtain coverage under this Plan.

An applicant with special enrollment rights must make application for Dependent Coverage during the Special Enrollment Period, which is generally during the first 30 days after the loss of other coverage or marriage, birth, adoption, or placement for adoption (whichever is applicable). However, if the loss of other coverage was caused by the application of the plan's lifetime limit on all benefits, the Special Enrollment Period will occur during the 30-day period immediately following the first date on which a claim was denied for that reason. Further, in the case of the loss of Medicaid or CHIP eligibility or the gain of eligibility for a Medicaid or CHIP premium assistance subsidy, the Special Enrollment Period is during the first 60 days after the loss or gain of eligibility. Dependent Coverage shall be effective as of the date of the loss of other coverage, the marriage, birth, adoption or placement for adoption, the loss of Medicaid or CHIP eligibility, or the gain of eligibility for a Medicaid or CHIP premium assistance subsidy.

An applicant with special enrollment rights who fails to make application for Dependent Coverage during the Special Enrollment Period must wait until the next Annual Open Enrollment Period or until special enrollment rights again apply, whichever occurs first.

Except for Newborn coverage, which shall begin at the moment of birth, Dependent Coverage under the Plan shall begin at 12:01 a.m. local time on the date on which coverage is to begin.

COURT- OR STATE-INITIATED QUALIFIED MEDICAL CHILD SUPPORT ORDERS

If an Employee participating in the Plan is required to provide health care coverage for a child pursuant to a Qualified Medical Child Support Order (QMCSO) initiated by a court or state administrative agency, the following rules apply:

- A. The Plan Administrator must receive notice of the order and must determine, in accordance with established procedures, that the order constitutes a QMCSO. If the Plan Administrator determines that the order constitutes a QMCSO, the remaining provisions in this section shall then apply.
- B. The child may be enrolled in the Plan without regard to any enrollment season restrictions (e.g., an Annual Open Enrollment Period, if available). Further, if the Employee fails to enroll the child, the child may, in accordance with applicable law, be enrolled by the state administrative agency initiating the QMCSO or by the non-covered parent. Further, the Plan Administrator cannot refuse to enroll the child because the child was born out of wedlock, was not claimed as a dependent on the Employee's federal income tax return, or does not reside with the Employee.
- C. The Employee must pay any required contributions for the child's coverage on the same basis as if the Employee elected Dependent Coverage for the child under the Plan. If the Employee fails to elect or is not eligible to elect the necessary

compensation reduction contributions for the child's coverage on a before-tax basis under any Section 125 plan maintained by the Employer, the Employer may withhold the required contributions from the Employee's paychecks on an after-tax basis to the extent permitted by applicable law.

- D. If the Employee is not the custodial parent, the Plan Administrator shall provide whatever information is needed to the custodial parent for the child to obtain benefits.
- E. If the Employee is not the custodial parent, the Plan Administrator shall permit the custodial parent to submit claims on behalf of the child without the approval of the Employee.
- F. If the Employee is not the custodial parent, the Plan Administrator may make benefit payments to the custodial parent or the state administrative agency initiating the QMCSO, in addition to any other parties to which payment may be made as provided by the Plan.
- G. The child's coverage under the Plan may not be terminated, except in the following circumstances:
 - 1. Required contributions for coverage have not been paid in a timely manner.
 - 2. There is written evidence that the QMCSO is no longer in effect.
 - 3. There is written evidence that the child is or will be enrolled in comparable health coverage that takes effect not later than the effective date of termination of coverage.
 - 4. The Employer has eliminated Dependent Coverage for all participating Employees.
- H. The Plan Administrator shall maintain procedures governing the determination as to whether an order constitutes a QMCSO. Covered Persons can obtain, without charge, a copy of the procedures from the Plan Administrator.

SWITCHING COVERAGE STATUS

If a Dependent is eligible to be enrolled as a Participant, enrollment may be effective on the date of the enrollment. If a Participant is eligible to be enrolled as a Dependent, enrollment may be effective on the date of the enrollment. Any switches in coverage status do not interrupt participation in the Plan and do not change a Covered Person's effective date of coverage.

PARTICIPANT CONTRIBUTION

The Employer may require a contribution from Participants in order to maintain Employee participation and/or the participation of any Dependents in the Plan. If Participant contributions are required, the Employer will notify the Participants of the designated amount. If the Employer maintains a Section 125 Plan, the required contributions may be paid on a pre-tax basis under that plan.

ANNUAL OPEN ENROLLMENT PERIOD

The Plan will offer an Annual Open Enrollment Period in June, July, and/or August each year for eligible individuals and their dependents to enroll or re-enroll for coverage under this Plan. For those individuals and their dependent(s), their elections will go into effect on September 1 following the Annual Open Enrollment Period.

An eligible individual may complete a new election form and return it to the Plan Administrator during the Annual Open Enrollment Period before the first day of the subsequent Plan Year. Further, the Plan Administrator may require an eligible individual to complete a new election form for a subsequent Plan Year. If neither one of these situations applies, an individual's election from the previous Plan Year shall automatically continue for the subsequent Plan Year.

Employees who satisfy the Participant Eligibility Requirements for full-time Employees as described on page 55 and who continue to be eligible for Participant Coverage may enroll or re-enroll for coverage under the Plan during the Annual Open Enrollment Period.

Any other Employee will be eligible to enroll or re-enroll for coverage under the Plan during the Annual Open Enrollment Period if he or she averaged 30 or more hours per week during the preceding 12-month Standard Measurement Period. Alternatively, an Employee who is eligible for coverage during his or her Initial Stability Period will be able to enroll or re-enroll for coverage under the Plan during the Annual Open Enrollment Period but coverage and the election will both terminate upon the expiration of the Initial Stability Period.

TERMINATION OF COVERAGE

PARTICIPANT TERMINATION

Participant Coverage terminates immediately upon the earliest of the following dates, except as provided in the Extension of Participation provisions:

- A. Date of termination of the Participant's employment.
- B. Date on which the Participant goes on a leave of absence, is laid-off, or is, on a regular basis, Actively at Work in employment by the Employer for less than the number of hours per week required to be initially eligible for coverage. However, a reduction in hours owing to a family or medical leave as defined by the FMLA shall not cause health coverage to end to the extent required by the FMLA nor

shall a reduction in hours during an Initial or Standard Stability Period cause health coverage to end to the extent required by Health Care Reform.

- C. Date on which the Participant ceases to be in a classification (if any) shown in the Schedule for Eligibility and Participation for Participant Coverage.
- D. The last day of the period for which the Participant fails to timely make any required contribution for coverage.
- E. Date on which the Plan is terminated; or with respect to any benefit(s) of the Plan, the date of termination of such benefit(s).
- F. Date on which the Plan Administrator terminates the Participant's coverage for cause, which includes a termination for fraud or misrepresentation (whether intentional or unintentional) in an application for enrollment or a claim for benefits. However, coverage generally cannot be retroactively rescinded absent fraud or intentional misrepresentation.
- G. Effective date of the Participant's notice of voluntary withdrawal. However, where required contributions for coverage are paid on a pre-tax basis through the Employer's Section 125 plan, a voluntary withdrawal may only occur during the Annual Open Enrollment Period (if applicable) or midyear as a result of a Change in Status or other qualifying event under the Employer's Section 125 plan.
- H. Date of the Participant's death.

Expenses incurred after the date of termination are not covered by the Plan unless an extension of participation applies (see Extensions of Participation section below).

REINSTATEMENT

Reinstatement is not available under this Plan, except as required by law. Accordingly, a veteran's right and entitlement to reinstatement on returning from military training or service shall be governed by the Uniformed Services Employment and Reemployment Rights Act (USERRA), and any other applicable laws or regulations. Further, see the Family and Medical Leave Act of 1993 (FMLA) section below regarding the right to reinstatement upon return to work from an FMLA leave. The Plan will also allow reinstatement to the extent required by Health Care Reform's break-in-service provisions (see the Participant Eligibility Requirements: Special Rules for All Employees section for more details). Otherwise, a Participant whose coverage terminates and who resumes employment with the Employer will be considered a new Employee for purposes of determining when or if coverage begins.

DEPENDENT TERMINATION

Dependent Coverage terminates immediately upon the earliest of the following dates, except as provided in the Extension of Participation provisions:

- A. Date on which the Dependent ceases to be a Dependent.

- B. Date of termination of the Participant's coverage under the Plan.
- C. The last day of the period for which the Participant fails to make any required contributions for Dependent Coverage in a timely manner.
- D. Date on which the Plan Administrator terminates the Dependent's coverage for cause, which includes a termination for fraud or misrepresentation (whether intentional or unintentional) in an application for enrollment or a claim for benefits. However, coverage generally cannot be retroactively rescinded absent fraud or intentional misrepresentation.
- E. Date on which the Dependent begins Participant Coverage under the Plan.
- F. Date on which the Plan or a benefit of the Plan is terminated.
- G. Effective date of the notice of voluntary withdrawal made by or on behalf of the Dependent. However, where required contributions for coverage are paid on a pre-tax basis through the Employer's Section 125 plan, a voluntary withdrawal may occur only during the Annual Open Enrollment Period (if applicable) or midyear as a result of a Change in Status or other qualifying event under the Employer's Section 125 plan.
- H. Date of the Dependent's death.

The Participant is obligated to immediately report to the Plan Administrator any change that would result in a Dependent's termination of coverage. Expenses incurred after the date of termination are not covered by the Plan unless an extension of participation applies (see Extensions of Participation section below).

EXTENSIONS OF PARTICIPATION

A Participant may have participation extended under Employer-provided extensions specified in the Schedule for Eligibility and Participation, under the FMLA, or under COBRA. Any Employer-provided extension of participation will apply before a COBRA extension of participation and will offset the length of a COBRA extension of participation, except to the extent that the Employer-provided extension of participation runs concurrently with an FMLA extension of participation. A COBRA extension of participation may not begin until an FMLA extension of participation ends.

Notwithstanding any of the following provisions concerning extensions of participation, coverage for the Participant or the Participant's Dependent(s) may be immediately reduced or terminated by amendment to the Plan or termination of the Plan. If an event causing the Participant's or the Dependent's coverage to terminate also causes another extension of participation, a new extension period will begin for the Participant or the Participant's Dependent(s) on the date of such event.

Coverage during an Employer-provided extension of participation shall be continued on the same basis and at the same contribution level as if the Participant had continued in Active Employment for the duration of the leave.

EMPLOYER-PROVIDED EXTENSIONS OF PARTICIPATION

Medical Leave Extension

Participation for a Participant and any eligible Dependents continues if the Participant suffers from Illness or Injury and has been granted a medical leave by the Employer under policies determined on a uniform, nondiscriminatory basis that precludes individual selection. This extension of participation begins on the date on which the Participant's approved medical leave begins. However, if the Participant's medical leave of absence constitutes an FMLA leave, the extension of participation shall run concurrently with and will be offset against the length of an FMLA extension. The extension terminates upon the expiration of the time period stated in the Schedule for Eligibility and Participation or the expiration of the approved medical leave, whichever occurs first.

Dependents' Extension if Participant Deceased

Participation for a Participant's Dependents continues if the Participant dies. This extension of participation begins on the date of the Participant's death and terminates at the end of the time period stated in the Schedule for Eligibility and Participation after the Participant's death, or when the spouse remarries, whichever occurs first.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

The FMLA provisions of the Plan apply during any Calendar Year when the Employer is subject to FMLA, which generally means the Employer employs 50 or more Employees (including part-time Employees) each working day during 20 or more calendar weeks in the current or preceding Calendar Year. Further, the FMLA provisions apply only to eligible Participants (i.e., Participants who have been employed by the Employer for at least 12 months and who have worked at least 1,250 hours in the 12-month period immediately preceding the taking of the FMLA leave). A Participant on leave under the FMLA may continue coverage during the leave on the same basis and at the same Participant contribution as if the Participant had continued in Active Employment continuously for the duration of the leave. The maximum period of an FMLA leave is generally 12 workweeks per 12-month period (as that 12-month period is defined by the Employer). However, if a Participant takes leave under the FMLA to care for a spouse, parent, child, or next of kin injured in the line of active military duty, the maximum period of FMLA leave is 26 workweeks per 12-month period. Other provisions regarding an FMLA leave are set forth in the FMLA and the Employer's policy regarding the FMLA. If the Participant fails to return from the FMLA leave for any reason other than the continuation, recurrence, or onset of a "serious health condition" as defined in the FMLA or other circumstance considered by the Plan Administrator as beyond the control of the Participant, the Employer may recover any Employer contribution paid to maintain coverage for the Participant during the leave. If a Participant fails to pay any required contribution for coverage during the FMLA leave within 30 days of the due date for the contribution, coverage shall be suspended upon 15 days advance written notification of the non-payment, subject to the right to reinstatement of coverage upon

return to work from FMLA leave with no waiting period or other limitation normally applicable to a new Participant in the Plan.

COBRA EXTENSIONS OF PARTICIPATION

During any Calendar Year following a Calendar Year in which the Employer had employed 20 or more Employees (including part-time Employees who are counted as a fraction of a full-time Employee) during at least 50% of the business days in the year, each person who is a Qualified Beneficiary shall have the right to elect to continue coverage under this Plan upon the occurrence of a Qualifying Event. Such extended coverage under the Plan is referred to as “Continuation Coverage.” This section explains the requirements of COBRA. Individuals with questions regarding COBRA that are not answered in this document should contact the Plan Administrator at the address and telephone number listed in the Other Basic Information About the Plan section.

To protect their rights under COBRA, individuals should inform the Plan Administrator of any changes in the address of family members. Individuals should also keep a copy, for their records, of any notices they send to the Plan Administrator.

A. Qualifying Event

Any of the following shall be considered a “Qualifying Event” if the event causes a loss of coverage under the Plan:

1. Death of a Participant.
2. Termination (other than by reason of gross misconduct) of the Participant’s employment or reduction of hours of the Participant’s employment below any minimum required for participation in the Plan. Notwithstanding the above, a leave under the FMLA shall not constitute a Qualifying Event until the last day of the FMLA leave.
3. Divorce or legal separation of a Participant from the Participant’s spouse.
4. A Participant becoming entitled to receive Medicare benefits under Title XVIII of the Social Security Act.
5. A Dependent child of a Participant ceasing to be a Dependent under the terms of the Plan (e.g., upon attainment of the age of majority).

B. Qualified Beneficiary

A “Qualified Beneficiary” is any person who, on the day before the occurrence of a Qualifying Event, is covered by the Plan as a Participant or a Dependent, unless one of the following exceptions applies:

1. A child born to or placed for adoption with a Participant after the Qualifying Event but before the end of the COBRA continuation period is a Qualified Beneficiary. However, the COBRA continuation period for

such a newborn or newly adopted child shall be measured from the date of the initial Qualifying Event, rather than on the subsequent date of birth or adoption or placement for adoption.

2. The spouse, former spouse, or Dependent children of a Participant are Qualified Beneficiaries upon the divorce or legal separation of the spouse and Participant, even if the Participant previously eliminated their coverage under the Plan in anticipation of the divorce or legal separation.

A child of the Participant who is covered under the Plan pursuant to a QMCSO can be a Qualified Beneficiary. A Participant can be a Qualified Beneficiary only if the Qualifying Event consists of termination of employment (for any reason other than gross misconduct) or reduction of hours of the Participant's employment.

Except as otherwise provided above, an individual is not a Qualified Beneficiary if, as of the day before the Qualifying Event, he or she is covered under the Plan by reason of the election of Continuation Coverage by another person and is not already a Qualified Beneficiary by reason of a prior Qualifying Event. Furthermore, an individual who fails to elect Continuation Coverage within the election period provided in Subsection I. below shall not be considered a Qualified Beneficiary.

C. Type of Coverage

Continuation Coverage means the group health coverage that is provided to similarly situated non-Qualified Beneficiaries. Generally, this term means the same health coverage provided to the Qualified Beneficiary immediately before the Qualifying Event. Alternatively, the Qualified Beneficiary may initially elect to purchase one or more of the available medical, prescription drug, dental, and vision coverages that are provided by the Employer pursuant to any separate group health plans and/or that may be separately elected pursuant to the Employer's Section 125 plan (if any). However, each coverage is initially available only if the Qualified Beneficiary was receiving the coverage immediately before the Qualifying Event. Any change in the Plan or in enrollment opportunities affecting similarly situated Active Employees, including, without limitation, a change in benefits under the Plan or any change in the Applicable Premium (see Subsection D. below), shall also apply to a Qualified Beneficiary. Continuation Coverage does not apply to group term-life insurance or short-term or long-term disability coverage, if available.

D. Cost of Continuation Coverage

The Employer is not responsible to contribute to the cost of Continuation Coverage. A Qualified Beneficiary who elects to continue coverage under the Plan shall be responsible to arrange for payment of the full cost of that coverage plus any additional amounts permitted by law (Applicable Premium).

A disabled Qualified Beneficiary who elects extended coverage under Subsection E(4) below shall be required to pay 150% of the full cost of coverage for each additional month of coverage after the initial 18-month period. The 150% cost amount shall also apply to the disabled Qualified Beneficiary's family members enrolled in Continuation Coverage, as long as the disabled Qualified Beneficiary is in the COBRA coverage group.

E. Duration of Continuation Coverage

1. *General Rule.* For a Qualifying Event caused by a Participant's termination or reduction in hours of employment, Continuation Coverage may extend for 18 months from the date of the Qualifying Event. For all other Qualifying Events, Continuation Coverage may extend for 36 months from the date of the Qualifying Event.
2. *Special Rule Where Coverage is Eliminated in Anticipation of Divorce.* Continuation Coverage may not be available to a Participant's spouse and Dependent children between the date coverage under the Plan is eliminated in anticipation of a divorce or legal separation and the date of the divorce or legal separation.
3. *Multiple Qualifying Events.* If, during an 18-month continuation period (or during the additional 11-month period in the event of disability, as described in Subsection E[4] below), another Qualifying Event that is a divorce, legal separation, the death of the Participant, or a child's loss of Dependent status under the Plan occurs, coverage may be extended for the Participant's Dependents for up to 36 months from the date of the original Qualifying Event. Notice of this second Qualifying Event must be provided to the Plan Administrator within 60 days of the date of the second Qualifying Event. If notice is not provided within this time period, the Qualified Beneficiaries shall be eligible for only 18 months of coverage, rather than 36 months.
4. *Special Rule for Disability.* In the case of a Qualified Beneficiary who is determined to be disabled before the original Qualifying Event or at any time during the first 60 days of Continuation Coverage, the maximum period of coverage for the disabled Qualified Beneficiary and the Qualified Beneficiaries who are his or her Dependents may be extended for an additional 11 months (29 months total from the date of the Qualifying Event).

For this purpose, a Qualified Beneficiary is disabled only if the Qualified Beneficiary receives a determination of disability under Title II (Old Age, Survivors and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act.

Notice of the disability determination must be provided to the Plan Administrator before the end of the initial 18-month continuation period

and within 60 days of the date of the disability determination or date of the Qualifying Event, if later. If notice is not provided within this time period, the Qualified Beneficiary shall be eligible for only 18 months of coverage, rather than 29 months.

The Qualified Beneficiary or the Qualified Beneficiary's representative must also notify the Plan Administrator within 30 days of any final determination that the Qualified Beneficiary is no longer disabled. The extended continuation coverage for disability shall terminate on the first day of the first month that begins more than 30 days after the date of the final determination that the Qualified Beneficiary is no longer disabled or, if earlier, on the date the Continuation Coverage for the Qualified Beneficiary would otherwise terminate.

5. *Special Rule for Medicare Entitlement.* If a Participant becomes entitled to Medicare during an 18-month continuation period, the maximum period of coverage for Qualified Beneficiaries other than the Participant may be extended to 36 months from the date of the original Qualifying Event if, ignoring the original Qualifying Event, the Participant's entitlement to Medicare would have been a Qualifying Event under the Plan.

If a Participant becomes entitled to Medicare before experiencing a Qualifying Event that is a reduction in hours or termination of employment, the maximum continuation period for the Qualified Beneficiaries who are the Participant's Dependents shall end on the later of 36 months after the date of the Participant's Medicare entitlement or 18 months (29 months if there is a disability extension) after the date of the reduction in hours or termination of employment.

Notice of the Participant's entitlement to Medicare must be provided to the Plan Administrator within 60 days of the date the Participant becomes entitled to Medicare or, if later, 60 days after the date of the Qualifying Event. If notice is not provided within this time period, the Qualified Beneficiaries who are the Participant's Dependents shall be eligible for only 18 months of coverage rather than 36 months.

F. *Plan Administrator's and Employer's Notice Obligations*

The Employer has the obligation to notify the Plan Administrator of certain Qualifying Events. The Plan Administrator has the obligation to provide a Participant, and the Participant's covered spouse (if any) with certain information about Continuation Coverage. This section describes those obligations.

1. *Plan Administrator's Initial Notice.* When an Employee becomes covered under this Plan, the Plan Administrator shall notify the Employee and the Employee's covered spouse (if any) of their rights under COBRA. The Plan Administrator shall provide this notice no later than the earlier of 90 days from the date on which the Employee and the Employee's covered

spouse (if any) first became covered under the Plan, or the date on which the Plan Administrator is required to provide the Participant or the Employee's Dependents with a notice of the right to elect Continuation Coverage (Election Notice).

The Plan Administrator may satisfy this requirement by providing a single notice addressed to both the Participant and the Participant's covered spouse (if any) where the Participant and covered spouse share a residence and the spouse's coverage begins before the date the initial notice is required to be provided to the Participant under this Subsection F(1).

2. Employer's Notice of Qualifying Event. The Employer has 30 days to notify the Plan Administrator of a Qualifying Event resulting from the death of the Participant, entitlement to Medicare, termination of employment, or reduction in hours from the date of its occurrence.
3. Election Notice from Plan Administrator. Within 14 days of receiving notice of the occurrence of a Qualifying Event (or a longer period as may be allowed by statute or regulation or as may be required to correct a COBRA failure), the Plan Administrator shall furnish each Qualified Beneficiary with notice of the right to elect Continuation Coverage (Election Notice).
4. Notice of Unavailability of Continuation Coverage. The Plan Administrator shall provide a notice of the unavailability of Continuation Coverage where the Plan Administrator determines that Continuation Coverage is not available after receiving notice of a potential Qualifying Event. The Plan Administrator shall also provide a notice of the unavailability of Continuation Coverage where the Plan Administrator determines that an extension of the Continuation Coverage period is not available after receiving notice of a potential second Qualifying Event, the Participant's entitlement to Medicare, or a Social Security disability determination (Extension Event).

The determination that Continuation Coverage or an extension of Continuation Coverage is not available could be made because the Plan Administrator determines that no Qualifying Event or Extension Event occurred, or because a Qualified Beneficiary's notice of a Qualifying Event or Extension Event was defective. A notice shall be defective if it is not provided within the applicable time limit or if it is not provided in accordance with the requirements of Subsections G. and H.

The Plan Administrator shall provide the notice of unavailability of Continuation Coverage within 14 days of the date the Plan Administrator receives the notice of the potential Qualifying Event or Extension Event, or, if later, the deadline for submission of additional information requested by the Plan Administrator to supplement a defective notice. The Plan Administrator shall send the notice of the unavailability of Continuation

Coverage to the individual who submitted the notice of the Qualifying Event or Extension Event and to all individuals for whom Continuation Coverage or an extension of the continuation period was potentially available.

In all cases, notice provided to a Participant, spouse of a Participant, or former spouse of a Participant is considered notice to all other Qualified Beneficiaries living with the Participant, spouse, or former spouse.

G. Qualified Beneficiary's Notice Obligations

In some situations, the Participant or his or her Dependents have the obligation to provide notice of a Qualifying Event or an Extension Event to the Plan Administrator. This section describes those obligations:

1. Qualified Beneficiary's Notice of Qualifying Event. If a Qualifying Event results from divorce, legal separation, or a child losing Dependent status under the terms of the Plan, the Participant, Qualified Beneficiary, or a representative acting on behalf of the Participant or Qualified Beneficiary must notify the Plan Administrator within 60 days of the loss of eligibility caused by the occurrence of the Qualifying Event.

Notice must be provided in accordance with the procedures set forth in Subsection H. below. If timely notice is not provided in the manner required under Subsection H., Continuation Coverage shall not be available as a result of the divorce, legal separation, or child's loss of Dependent status under the Plan.

2. Qualified Beneficiary's Notice of Second Qualifying Event. In order to qualify for an extension of Continuation Coverage as described in Subsection E(3), a Qualified Beneficiary must notify the Plan Administrator of a second Qualifying Event that is a divorce or legal separation, the death of the Participant, or a child's loss of Dependent status under the Plan within 60 days of the date of the second Qualifying Event.

Notice must be provided in accordance with the procedures set forth in Subsection H. below. If timely notice is not provided in the manner required under Subsection H., Continuation Coverage shall not be extended beyond the initial 18-month period.

3. Qualified Beneficiary's Notice of Disability Determination. In order to qualify for the additional 11-month continuation period described in Subsection E(4), a disabled Qualified Beneficiary must provide the Plan Administrator with notice of the determination of disability before the end of the initial 18-month continuation period and within 60 days after the date of the determination. However, a special rule applies where the determination of disability was made before the date of the initial

Qualifying Event. In that event, the disabled Qualified Beneficiary must provide written notice of the determination of disability within 60 days after the date of the initial Qualifying Event.

Notice must be provided in accordance with the procedures set forth in Subsection H. below. If timely notice is not provided in the manner required under Subsection H., Continuation Coverage shall not be extended beyond the initial 18-month period.

4. Qualified Beneficiary's Notice of Medicare Entitlement. In order to qualify for the extension of Continuation Coverage described in Subsection E(5), a Qualified Beneficiary must notify the Plan Administrator of the Participant's entitlement to Medicare within 60 days of the later of the date the Participant becomes entitled to Medicare or the date of the initial Qualifying Event.

Notice must be provided in accordance with the procedures set forth in Subsection H. below. If timely notice is not provided in the manner required under Subsection H., Continuation Coverage shall not be extended beyond the initial 18-month period.

H. Notice Procedures for Qualified Beneficiaries

A Participant, Qualified Beneficiary, or the representative of a Participant or Qualified Beneficiary must provide the notices described in Subsection G. to the Plan Administrator at the address listed in the Other Basic Information About the Plan section. Notice to any other person or entity shall be deemed to be defective.

The Plan Administrator has a form that can be used to provide the required notice. The form can be obtained by contacting the Plan Administrator at the address or telephone number in the Other Basic Information About the Plan section. While use of this form will help ensure that a Participant or Qualified Beneficiary provides all of the required information, the form is not mandatory. The Plan Administrator will also accept written notification that contains all of the following information (as applicable):

1. The name of the Participant.
2. The name of the individual(s) for whom Continuation Coverage or an extension of the continuation period is being requested (i.e., the Qualified Beneficiary[ies]).
3. The date of the Qualifying Event or Extension Event.
4. The current address of the individual(s) for whom Continuation Coverage or an extension of the continuation period is being requested.
5. The nature of the Qualifying Event or Extension Event (e.g., divorce).

Additionally, the following information should accompany the written notification (as applicable):

1. If the notice relates to a divorce, a copy of the judgment of divorce, as signed by the judge.
2. If the notice relates to a legal separation, a copy of the judgment of separate maintenance or other relevant court document establishing the legal separation.
3. If the notice relates to the Participant's entitlement to Medicare, a copy of the document(s) establishing the entitlement.
4. If the notice relates to a determination that a Qualified Beneficiary is entitled to social security disability benefits, a copy of the disability determination.
5. If the notice relates to a determination that a Qualified Beneficiary is no longer entitled to social security disability benefits, a copy of the determination.

Notice of a Qualifying Event must be provided within 60 days after the later of the occurrence of the event or the date coverage is lost owing to the Qualifying Event. Notice of an Extension Event must be provided within the time limit that applies to that event, as described in Subsections E(3), E(4), and E(5). **Failure to provide notice within the applicable time period and in accordance with the procedures described in this Subsection H. may result in forfeiture of the right to Continuation Coverage or an extension of the continuation period.**

If the Plan Administrator receives a written notice of a Qualifying Event or Extension Event that does not contain all of the required information, the Plan Administrator shall request the missing information. If all of the requested information is not provided, in writing, within 30 days of the date the Plan Administrator requests the additional information, the Plan Administrator shall reject the notice. If the notice is rejected, Continuation Coverage or an extension of the continuation period may not be available with respect to that potential Qualifying Event or Extension Event.

After reviewing the information submitted with the notice, the Plan Administrator may also request, in writing, additional information or documentation the Plan Administrator deems necessary to determine whether a Qualifying Event or Extension Event has occurred. If the additional information or documentation is not provided within 30 days of the date the Plan Administrator requests the information or documentation, the Plan Administrator may determine that Continuation Coverage or an extension of the continuation period is not available.

I. Time Period for Electing Continuation Coverage

A Qualified Beneficiary shall have 60 days from the date the Election Notice is mailed or hand-delivered to the Qualified Beneficiary or, if later, from the date of the Qualifying Event or the date coverage terminates (e.g., after an Employer-provided extension of participation) to return a signed election form to the Plan Administrator electing Continuation Coverage under the Plan. Failure to mail or otherwise return the signed election form to the Plan Administrator within the 60-day period shall be considered a refusal of the coverage.

Special COBRA election rights may apply if a Participant terminates employment or experiences a reduction in hours and qualifies for a “trade adjustment allowance” or “alternative trade adjustment assistance” under federal trade laws. In this situation, the Participant is entitled to a second opportunity to elect Continuation Coverage for the Participant and certain family members (if they did not already elect Continuation Coverage) but only within a limited period of 60 days (or less) and only during the six months immediately after Employer-provided group health plan coverage ends.

J. Termination of Continuation Coverage

Notwithstanding any other provision in this Plan, Continuation Coverage shall automatically terminate when any of the following occur:

1. The Employer no longer offers group health coverage to any of its Employees.
2. The Applicable Premium for Continuation Coverage is not paid within 30 days of the due date provided by the Employer (45 days for initial payment).
3. If after the date of the election of Continuation Coverage, a Qualified Beneficiary becomes covered (either as an employee or otherwise) under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the Qualified Beneficiary, other than a limitation or exclusion that does not apply to the Qualified Beneficiary or is satisfied by the Qualified Beneficiary on account of the Health Insurance Portability and Accountability Act.
4. If after the date of the election of Continuation Coverage, a Qualified Beneficiary becomes entitled to receive benefits under Title XVIII of the Social Security Act (Part A or Part B of Medicare).
5. A Qualified Beneficiary’s coverage is terminated for cause on the same basis that the Plan terminates for cause the coverage of similarly situated non-Qualified Beneficiaries (e.g., for fraud or misrepresentation in a claim for benefits).

If a Qualified Beneficiary becomes covered under another group health plan or becomes entitled to Medicare, the Qualified Beneficiary should immediately notify the Plan Administrator. The Plan Administrator shall notify the Qualified Beneficiary if Continuation Coverage terminates before the end of the initial 18- or 36-month continuation period or before the end of any additional 11- or 18-month continuation period for which the Qualified Beneficiary is eligible to elect Continuation Coverage. The Plan Administrator shall provide the notification as soon as practicable following the Plan Administrator's determination that Continuation Coverage shall terminate. Notice of the termination that is provided to a Participant, spouse of a Participant, or former spouse of a Participant is considered notice to all other Qualified Beneficiaries living with the Participant, spouse, or former spouse.

CONTINUATION OF COVERAGE UPON MILITARY LEAVE

If an Employee ceases to be eligible for health coverage under the Plan owing to service in the U.S. military, the Plan shall comply with the requirements of the Uniformed Services Employment and Reemployment Rights Act (USERRA). These requirements include the following:

- A. The Employee and any Dependents may elect to continue health coverage under the Plan. Health coverage will be available until the earliest of the following:
 - 1. The expiration of the 24-month period following the Employee's last day of work before beginning service in the U.S. military.
 - 2. The end of the period allowed by law for the Employee to apply for reemployment following the Employee's service in the U.S. military.
- B. USERRA continuation coverage shall run concurrently with an extension of coverage under COBRA.
- C. If the Employee gives the Employer advance notice of the Employee's service in the U.S. military, the Plan Administrator shall provide the Employee with a notice of the right to continue health coverage pursuant to USERRA. If the Employee's service in the U.S. military exceeds 30 days and the Employee fails to return the completed election form to the Plan Administrator within 60 days of the date the election form was provided to the Employee, the Employee and any Dependents shall cease to be eligible to continue coverage pursuant to USERRA as of the Employee's last day of work before beginning service in the U.S. military.

- D. If the Employee fails to give the Employer advance notice of the Employee's service in the U.S. military, the health coverage of the Employee and any Dependents shall be cancelled. However, the health coverage of the Employee and any Dependents may be reinstated retroactively to the first day the Employee was absent from work for service in the U.S. military under all of the following circumstances:
1. The Employee is excused from providing advance notice of the Employee's service in the U.S. military as provided under USERRA regulations (e.g., it was impossible or unreasonable for the Employee to provide advance notice, or the advance notice was precluded by military necessity).
 2. The Employee elects to reinstate the coverage.
 3. The Employee pays all unpaid premiums for the retroactive coverage.
- E. The Employee must pay for USERRA continuation coverage. Coverage continued pursuant to USERRA shall be cancelled if the Employee does not timely pay any required premiums for that coverage. The Employee's cost of the coverage is determined as follows:
1. If the period of military service is 30 days or less, the Employee's required contributions for health coverage will equal the required contributions for the identical coverage paid by similarly situated Active Employees.
 2. If the period of military service is more than 30 days, the Employee's required contributions will be 102% of the cost of identical coverage for similarly situated Active Employees.
- F. The initial premium is due within 45 days after the Employee elects to continue coverage, and subsequent premiums are due on the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after the Employee initially elects USERRA continuation coverage. Coverage shall be suspended if payment is not made by the first day of the month, but will be reinstated retroactively to the first of the month as long as payment for that month is made before the end of the grace period. Payment more than 30 days late will result in automatic termination of USERRA continuation coverage pursuant to this section with no right to reinstate.
- G. Upon reemployment, the health coverage of the Employee and any Dependents shall be immediately reinstated under the Plan (i.e., no waiting period shall apply).

GENERAL PROVISIONS

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the payment of benefits that exceed expenses. It applies when the Participant or any Dependent who is covered by this Plan is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plan(s) pay a reduced benefit. This Plan will always pay either its benefits in full or a reduced amount that, when added to the benefits payable by the other plan or plans, will not exceed 100% of Allowable Expenses. Only the amount paid by this Plan will be charged against the Plan maximums.

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

The Plan Administrator and Claim Administrator may release to, and obtain from, any other insurer, plan, or party any information that it deems necessary for the purposes of this section. A Covered Person shall cooperate in obtaining information and shall furnish all information necessary to implement this provision.

DEFINITIONS

The term “plan,” as used in this section to refer to a plan other than this Plan, means any of the following providing benefits or services for health, medical, or dental care or treatment:

- A. Group and nongroup insurance and subscriber contracts.
- B. Health maintenance organization (HMO) contracts.
- C. Closed panel plans or other forms of group or group-type coverage (whether insured or uninsured).
- D. Medical care components of long-term care contracts, such as skilled nursing care.
- E. Health benefits under group or individual automobile contracts.
- F. Health benefits under group or individual motorcycle contracts.
- G. Medicare or any other federal governmental plan, as permitted by law.

The term “plan” as used in this section does not include any of the following:

- A. Hospital indemnity coverage benefits or other fixed indemnity coverage.
- B. Accident only coverage.
- C. Specified disease or specified accident coverage.

- D. Limited benefit health coverage, as defined by state law.
- E. School accident-type coverage.
- F. Benefits for non-medical components of long-term care policies.
- G. Medicare supplement policies.
- H. Medicaid policies.
- I. Coverage under other federal governmental plans, unless permitted by law.

The term “Allowable Expense” means a health care expense, including deductibles, coinsurance and co-payments, that is covered at least in part by any plan covering the Covered Person. Any expense that is not covered by any plan covering the Covered Person is not an Allowable Expense. For example, the difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable Expense unless one of the plans provides coverage for private Hospital room charges. Further, the amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with that plan’s provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

The term “Primary Plan” means the plan that pays benefits first. The Primary Plan must pay benefits in accordance with its terms without taking into consideration the existence of another plan.

The term “Secondary Plan” means any plan that pays benefits after the Primary Plan. The Secondary Plan may reduce benefits so that the payments from all plans do not exceed 100% of the total Allowable Expense.

COORDINATION OF BENEFITS PROCEDURE

The Coordination of Benefits Procedure determines how the benefits provided by the Plan will be coordinated with the benefits provided by any other plans covering a Covered Person for whom a claim is made.

The amount of expenses considered for benefits under this Plan, as a Secondary Plan, will only be the amount of eligible expenses not paid or reimbursed by the Primary Plan(s). Any expenses considered for benefits under this Plan are subject to all provisions stated in the Plan.

COORDINATION WITH OTHER COVERAGE FOR INJURIES ARISING OUT OF AUTOMOBILE ACCIDENTS

Notwithstanding the Payment Priorities rules set forth below, the following special coordination rule applies regarding automobile insurance. If a Covered Person has automobile insurance (including, but not limited to no-fault) that provides health benefits, this Plan shall be the Primary Plan and the automobile insurance shall be the Secondary Plan for purposes of paying benefits.

PAYMENT PRIORITIES

Each plan makes its claim payment in the following order, if Medicare is not involved (except as provided in paragraph C. below):

- A. A plan that contains no provision for coordination of benefits, states that its coverage is primary, or does not have the same rules of priority as those listed below shall be the Primary Plan and pay before all other plans, including this Plan, and this Plan shall have only secondary liability.
- B. Except as provided in paragraph C., a plan that covers the claimant other than as a dependent (e.g., as an employee or retiree) shall pay before the plan that covers the claimant as a dependent.
- C. If the claimant is a Medicare beneficiary and, as a result of federal law, Medicare is (1) secondary to a plan covering the claimant as a dependent and (2) primary to a plan covering the claimant other than as a dependent (e.g. as a retiree), then, with respect to the two non-Medicare plans, the order in paragraph B. is reversed so that:
 1. The plan covering the claimant as a dependent is primary and
 2. The plan covering the claimant other than as a dependent is secondary.

In other words, in this situation, the plan covering the claimant as a dependent pays first, Medicare pays second, and the plan covering the person other than as a dependent pays third.

See the Coordination With Medicare section for information regarding when this Plan is primary or secondary to Medicare under federal law.

- D. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan, the order of benefits is determined as follows:
 1. If the dependent child's parents are married or living together, whether or not they have ever been married, the plan of the parent whose birthday falls first (omitting year of birth) in the Calendar Year is the Primary Plan. If both parents have the same birthday, the plan that has covered the parent the longest is the Primary Plan. This process is known as the "birthday rule."
 2. If the dependent child's parents are divorced or separated or are not living together, whether or not they have ever been married, payment shall be made as follows:
 - a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that

plan is the Primary Plan. This rule applies to plan years commencing after that plan is given notice of the court decree.

- b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the birthday rule will determine the order of benefits.
- c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the birthday rule will determine the order of benefits.
- d. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - i. The plan covering the custodial parent.
 - ii. The plan covering the spouse of the custodial parent.
 - iii. The plan covering the non-custodial parent.
 - iv. The plan covering the spouse of the non-custodial parent.

For this purpose, the custodial parent is the parent awarded custody of the child by court decree. In the absence of a court decree, the parent with whom the child resides more than one-half of the Calendar Year without regard to any temporary visitation shall be considered the custodial parent.

For purposes of this subsection, a parent's "plan" shall include any plan under which the parent has coverage (either as an employee, a dependent spouse, or otherwise).

- 3. If the dependent child is covered under more than one plan of individuals who are not the parents of the child, the provisions of this subsection shall determine the order of benefits as if those individuals were the parents of the child.
- E. The plan that covers the claimant as an active employee or dependent of an active employee shall pay before the plan that covers the claimant as an inactive employee (e.g., an employee who is laid off or retired) or dependent of such an inactive employee. This rule does not apply if the rules under paragraphs B. or C. can determine the order of benefits.
- F. If a claimant has coverage provided under COBRA or under a right of continuation by state or other federal law ("continuation coverage") and also has coverage under another plan, the plan covering the claimant as an employee or retiree (or as the dependent of an employee or retiree) is the Primary Plan and the

continuation coverage is the Secondary Plan. This rule does not apply if the rules under paragraphs B. or C. can determine the order of benefits.

- G. Covered Persons eligible for Medicaid shall be subject to the following provisions with respect to a state Medicaid program:
1. The Plan will pay benefits with respect to a Covered Person in accordance with any assignment of rights made by or on behalf of the Covered Person under a state plan for medical assistance approved under Title XIX of the Social Security Act (Medicaid).
 2. The Plan will not take into account the fact that an individual is eligible for or receives Medicaid assistance when considering eligibility for coverage or when determining or making benefit payments under the Plan.
 3. To the extent payment has been made under Medicaid in any case in which the Plan has a legal liability for such payment, then payment under this Plan will be made in accordance with any state law that provides that the state has acquired the rights with respect to a Covered Person for such payment.
- H. If the order set out in paragraphs A. through G. above does not apply in a particular case, the plan that has covered the claimant for the longest period of time shall pay first. To determine the length of time a person has been covered under a plan, two or more successive plans shall be treated as one plan if the claimant was eligible under the successor plan within 24 hours after the prior plan's coverage ended.

These coordination of benefit rules are intended to follow the National Association of Insurance Commissioners (NAIC) group coordination of benefits model regulation. The Plan's coordination of benefit rules shall be interpreted accordingly. To the extent the NAIC model regulation is subsequently amended, the Plan's coordination of benefit rules shall be amended accordingly.

The Plan Administrator has the right to do the following:

- A. Obtain from or share information with an insurance company or other organization regarding coordination of benefits, without the claimant's consent.
- B. Require that the claimant provide the Plan Administrator with information regarding other plans in which the claimant may participate or be eligible to participate so that this provision may be implemented. A claimant's intentional nondisclosure under this provision shall constitute a misrepresentation in a claim for benefits for purposes of the Termination of Coverage section.
- C. Pay the amount due under this Plan to an insurer or other organization if necessary, in the Plan Administrator's opinion, to satisfy the terms of this provision.

FACILITY OF PAYMENT

Whenever a Covered Person or provider to whom payments are directed becomes mentally, physically, or legally incapable of receiving or acknowledging receipt of such payments, neither the Employer nor the Trustee, if any, shall be under any obligation to see that a legal representative is appointed or to make payments to such legal representative if appointed. A determination of payment made in good faith shall be conclusive on all persons. The Plan Administrator, the Employer, and Trustee, if any, shall not be liable to any person as the result of a payment made and shall be fully discharged from all future liability with respect to a payment made. Payments may be made in any one or more of the following ways, as determined by the Plan Administrator in its sole discretion:

- A. Directly to the Covered Person or provider.
- B. To the legal representative of the Covered Person or provider.
- C. To a Close Relative or other relative by blood or marriage of the Covered Person or provider.
- D. To a person with whom the Covered Person or provider resides.
- E. By expending the amount directly for the exclusive benefit of the Covered Person or provider.

COORDINATION WITH MEDICARE

The Plan must provide benefits in accordance with the programs established by Title I of Public Law 89-98, as amended, entitled “Health Insurance for the Aged Act,” that includes parts A and B of Subchapter XVIII of the Social Security Act, as amended, and any other applicable federal laws or regulations. If the applicable laws or regulations are changed, the Plan is automatically amended to conform to such laws or regulations, including allowing the Plan to become secondary to Medicare. As used in this section, the term “current employment status” has the same meaning as under 42 CFR § 411.104.

If a Covered Person is also eligible for Medicare, whether this Plan or Medicare is the primary payer depends upon the reason for the Covered Person’s Medicare eligibility.

- A. If the Medicare eligibility is because of Total Disability, this Plan will be the Primary Plan and Medicare the Secondary Plan if the Employer had 100 or more full-time or part-time employees on 51% or more of its regular business days during the preceding Calendar Year and the Participant’s coverage is based on current employment status.

On the other hand, if the Employer had fewer than 100 full-time or part-time employees on 51% or more of its regular business days during the preceding Calendar Year, or if the Participant’s coverage is not based on current employment status (i.e., the Participant has terminated employment or lost coverage owing to a reduction in hours and is on COBRA or is receiving retiree

coverage), Medicare will be the Primary Plan and this Plan will be the Secondary Plan.

If a Participant has a Dependent who is Totally Disabled, these same coordination of benefits rules will apply to the Dependent.

- B. If the Medicare eligibility is because of End Stage Renal Disease (ESRD), this Plan will be the Primary Plan and Medicare the Secondary Plan – at least for the period of time prescribed by law.
- C. If the Medicare eligibility is because the Participant or the Participant's Dependent spouse attains age 65, Medicare will be the Primary Plan and this Plan will be the Secondary Plan if the Employer had fewer than 20 employees for each working day in 20 or more weeks in either the current or preceding Calendar Year or if the Participant's coverage is not based on current employment status (i.e., the Participant has terminated employment or lost coverage owing to a reduction in hours and is on COBRA or is receiving retiree coverage).

On the other hand, if the Participant's coverage continues to be based on current employment status after attaining age 65 and the Employer had 20 or more employees for each working day in 20 or more weeks in either the current or preceding Calendar Year, this Plan will be the Primary Plan and Medicare the Secondary Plan unless the Participant declines primary coverage under this Plan.

If a Participant has a Dependent spouse who attains age 65, these same coordination of benefits rules will apply to the spouse.

- D. For purposes of paragraphs A. and C., "Employer" includes any entity that is a member of Plan Sponsor's affiliated service group, as defined in Section 414(m) of the Code, and any entity that is at least 50% commonly owned with Plan Sponsor as defined in subsections (a) or (b) of Section 52 of the Code. If, as a result of the rules under paragraphs A., B., or C. of this section, Medicare is secondary to a plan covering the Covered Person as a Dependent and primary to a plan covering the Covered Person other than as a Dependent (e.g., as a retiree), then the rule under paragraph C. of the Payment Priorities section shall determine the order of the benefits.

As stated above, federal law prescribes these rules; if the applicable laws or regulations are changed, the Plan is automatically amended to conform to such laws or regulations. See the Plan Administrator for details.

In determining benefits payable under Medicare, the Plan will process claims as if the Covered Person is enrolled for all Medicare benefits for which the Covered Person is eligible, even if the Covered Person fails to enroll in Medicare (Part A and/or Part B) or if the provider does not participate in Medicare (i.e., has opted out).

PLAN'S RIGHT TO REIMBURSEMENT AND SUBROGATION RIGHT

Plan's Right to Reimbursement

If the Plan pays benefits and another party (other than the Covered Person or the Plan) is or may be liable for the expenses, the Plan has a right of reimbursement that entitles it to recover from the Covered Person or another party 100% of the amount of benefits paid by the Plan to or on behalf of the Covered Person.

The Plan's right to 100% reimbursement applies to the following:

- A. Not only to any recovery the Covered Person receives or is entitled to receive from the other party but also to any recovery the Covered Person receives or is entitled to receive from the other party's insurer or a plan under which the other party has coverage.
- B. To any recovery from the Covered Person's own insurance policy, including, but not limited to, coverage under any uninsured or underinsured policy provisions.
- C. To any recovery, even if the other party is not found to be legally at fault for causing the Covered Person to incur the expenses paid or payable by the Plan.
- D. To any recovery, even if the damage recovered or recoverable from the other party, its insurer or plan, or the Covered Person's policy is not for the same charges or types of losses and damages as those for which benefits were paid by the Plan.
- E. To any recovery, regardless of whether the recovery fully compensates the Covered Person for his or her Injuries and Illnesses and regardless whether the Covered Person is made whole by the recovery.
- F. To the entire amount of the recovery to the extent of the expenses payable by the Plan. The Plan's right to reimbursement from the recovery is in the first priority and is not offset or reduced in any way by the Covered Person's attorney's fees or costs in obtaining the recovery. The Plan disavows any obligation to pay all or any portion of the Covered Person's attorney's fees or costs in obtaining the recovery. The common fund doctrine and other similar common law doctrines do not reduce or affect the Plan's right to reimbursement.

Plan's Subrogation Right to Initiate Legal Action

If a Covered Person does not bring an action against the other party who caused the need for the benefits paid by the Plan within a reasonable period of time after the claim arises, the Plan shall have the right to bring an action against the other party to enforce and protect its right to reimbursement. In this circumstance, the Plan shall be responsible for its own attorney's fees.

Cooperation of Covered Person

A Covered Person shall do whatever is necessary and shall cooperate fully to secure the rights of the Plan. This includes assigning the Covered Person's rights against any other party to the Plan and executing any other legal documents that may be required by the Plan.

Plan's Right to Withhold Payment

The Plan may withhold payment of benefits when it appears that a party other than the Covered Person or the Plan may be liable for the expenses until such liability is legally determined. Further, as a precondition to paying benefits when it appears that the need for the benefits payable by the Plan was caused by another party, the Plan may withhold the payment of benefits until the Covered Person signs an agreement furnished by the Plan Administrator setting forth the Plan's right to reimbursement and subrogation right.

Preconditions to Participation and the Receipt of Benefits

All of the following rules are preconditions to an individual's participation in the Plan and the receipt of Plan benefits:

- A. The Covered Person agrees not to raise any make-whole, common fund, or other apportionment claim or defense to any action or case involving reimbursement or subrogation in connection with the Plan, and acknowledges that the Plan expressly disavows such claims or defenses.
- B. The Covered Person agrees not to raise any jurisdictional or procedural issue that would defeat the Plan's claim to reimbursement or subrogation in connection with the Plan.
- C. The Covered Person specifically acknowledges the Plan's fiduciary right to bring an equitable reimbursement recovery action should the Covered Person obtain or be entitled to obtain a recovery from another party who is or may be liable for the expenses paid by the Plan and to obtain an equitable lien over any property or recovery to the extent of the expenses payable by the Plan.
- D. The Covered Person specifically recognizes that the Plan has the right to intervene in any third party action to enforce its reimbursement rights. The Covered Person consents to such intervention.
- E. The Covered Person specifically agrees that the Plan has the right to obtain injunctive relief prohibiting the Covered Person from accepting or receiving any settlement or other recovery related to the expenses paid by the Plan until the Plan's right to reimbursement is fully satisfied. The Covered Person consents to such injunctive relief.

Notice and Settlement of Claim

A Covered Person shall give the Plan Administrator written notice of any claim against another party as soon as the Covered Person becomes aware that he may recover damages from another

party. A Covered Person shall be deemed to be aware that he may recover damages from another party upon the earliest of the following events:

- A. The date the Covered Person retains an attorney in connection with the claim.
- B. The date a written notice of the claim is presented to another party or the other party's insurer or attorney by the Covered Person or by the Covered Person's insurer or attorney.

A Covered Person shall not compromise or settle any claim against another party without the prior written consent of the Plan Administrator. If a Covered Person fails to provide the Plan Administrator with written notice of a claim as required in this section, or if a Covered Person compromises or settles a claim without prior written consent as required in this section, the Plan Administrator shall deem the Covered Person to have committed fraud or misrepresentation in a claim for benefits and accordingly, shall terminate the Covered Person's participation in the Plan.

PROVISIONAL PAYMENT OF DISPUTED CLAIM

In the event of a conflict between the Coordination of Benefits provisions of this Plan and any other plan, the Plan Administrator may take such action as it considers reasonably necessary to avoid hardship caused by a delay in payment of the disputed claim, including payment of such claim with reservation of the Plan's rights of recovery from the other plan in accordance with the reimbursement and subrogation provisions of this Plan.

CLAIMS PROCEDURE

NOTICE AND PROOF OF CLAIM

Written notice of Injury or Illness upon which a claim may be based should be given to the Plan Administrator within 30 days of the date on which the first loss occurred for which benefits arising out of such Injury or Illness may be claimed, or as soon as reasonably possible. The written notice must identify the Covered Person and the nature of the Injury or Illness. **Failure to provide notice within 12 months following the end of the Plan Year during which the first loss occurred for which benefits arising out of such Injury or Illness may be claimed shall invalidate the claim.** However, this time limit shall not apply where the reason for the delay was the failure of a third party provider to supply evidence necessary to provide the notice or caused by some other circumstance outside the Covered Person's control.

The Plan Administrator, upon receiving the notice required by the Plan, will provide the claimant with any forms necessary for filing a proof of loss. If the Plan Administrator does not provide the necessary forms within 15 days after receiving such notice, the claimant can meet the requirements of the Plan regarding proof of loss by submitting (within the time frame fixed in the Plan for filing proofs of loss) written proof of the occurrence, character, and extent of the loss for which the claim is made.

A claimant may appoint an authorized representative to act on his or her behalf in pursuing a benefit claim or in appealing an adverse benefit determination.

EXAMINATION AND RELEASE OF MEDICAL INFORMATION

The Plan Administrator shall have the right and opportunity to have a claimant examined whenever and as often as reasonably required during the pending of a claim. The Plan Administrator shall also have the right and opportunity to have an autopsy performed in case of death, where not forbidden by law. Further, as a condition of receiving benefits under the Plan, the claimant authorizes the release of all necessary medical information and records in order to process a claim.

INITIAL DECISION

The Plan Administrator will notify a claimant of the Plan's benefit determination as follows:

- A. **Urgent Care Claims.** An urgent care claim is a pre-service claim for medical care or treatment to which the application of the time periods for making non-urgent care claim determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or would, in the opinion of a Physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim. The Plan Administrator shall notify the claimant of the Plan's benefit determination regarding an urgent care claim as soon as possible, consistent with the medical exigencies involved, but no later than 72 hours after receipt of the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan Administrator shall notify the claimant within 24 hours after receiving the claim of the information necessary to complete the claim. The claimant shall then be granted 48 hours to provide the information. The Plan Administrator shall notify the claimant of the Plan's benefit determination within 48 hours after the earlier of the receipt of the information or the end of the period granted the claimant to provide the information.

- B. **Pre-Service Claims.** A pre-service claim is a claim for a benefit that is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining medical care. The Plan Administrator shall notify the claimant of the Plan's benefit determination regarding a pre-service claim within 15 days after receipt of the claim. The Plan Administrator may extend this period one time for up to 15 days if it determines that such an extension is necessary owing to matters beyond its control. The Plan Administrator must notify the claimant, before the expiration of the initial 15-day period, of the circumstances requiring the extension and the date it expects to make a decision. If the extension is necessary because the claimant failed to submit the information required to decide the claim, the notice of the extension shall describe this required information, and the claimant will be granted 45 days from receipt of the notice to provide the information. The Plan Administrator will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the

notice of extension, the Plan Administrator may issue a denial of the claim within 15 days after the expiration of the 45-day period.

- C. Post-Service Claims. A post-service claim is a claim for a benefit that is not a pre-service claim or an urgent care claim. If the Plan Administrator denies a post-service claim, in whole or in part, it shall notify the claimant of the adverse determination within 30 days after receipt of the claim. The Plan Administrator may extend this period one time for up to 15 days, if it determines that such an extension is necessary owing to matters beyond its control. The Plan Administrator must notify the claimant, before the expiration of the initial 30-day period, of the circumstances requiring the extension and the date it expects to make a decision. If the extension is necessary because the claimant failed to submit the information required to decide the claim, the notice of extension shall describe this required information, and the claimant will be granted 45 days from the receipt of the notice to provide the information. The Plan Administrator will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan Administrator may issue a denial of the claim within 15 days after the expiration of the 45-day period.
- D. Concurrent Care Claims. A concurrent care claim is a claim approved by the Plan Administrator for an ongoing course of treatment to be provided over a period of time or over a number of treatments. If the Plan Administrator reduces or terminates that course of treatment (other than by Plan amendment or termination), it has issued an adverse benefit determination. The Plan Administrator will provide notice, in accordance with the Benefit Determination Notice section below, at least 30 days before reducing or terminating the course of treatment in order to give the claimant time to appeal the reduction or termination. However, special rules apply in the case of a course of treatment for urgent care. The Plan Administrator shall decide any request to extend a course of treatment for urgent care as soon as possible and shall notify the claimant of its determination within 24 hours (if the claimant makes the claim to the Plan Administrator at least 24 hours before the expiration of the prescribed course of treatment for urgent care).

BENEFIT DETERMINATION NOTICE

The Plan Administrator will provide the claimant with a written or electronic notification of any adverse benefit determination. The notice will set forth the reason or reasons for the adverse determination, and refer to the Plan provisions on which the determination is based. The notice will also describe the Plan's review procedures and related time limits, and will include a statement of the claimant's right to bring a civil action following an adverse benefit determination on review.

If the Plan Administrator based the adverse benefit determination upon an internal rule, guideline, protocol, or other similar criterion, the notice will state that the Plan Administrator relied upon this information and that it will provide a free copy of the same to the claimant upon

request. If the Plan Administrator based the adverse benefit determination on a Medically Necessary, Experimental treatment, or similar exclusion or limit, the notice will state that the Plan Administrator will provide an explanation of the determination free of charge to the claimant upon request.

APPEAL OF DENIAL

The claimant may request a review of an adverse benefit determination by submitting a written application to the Plan Administrator within 180 days following the denial of the claim. The claimant may submit written comments, documents, records, and other information relating to the claim. The Plan Administrator will consider the information without regard to whether it was submitted or considered in the initial benefit determination. In filing the appeal, the Plan Administrator will provide the claimant, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits. For this purpose, a document, record, or other information is relevant if the Plan Administrator relied upon it in making the benefit determination; if it was submitted, considered, or generated in the course of making the benefit determination; or if it constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The appeal procedure will provide for a review that does not defer to the initial adverse benefit determination. The appeal will be conducted by an appropriately named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor a subordinate of that individual. If the appeal is based in whole or in part on a medical judgment (including a determination of whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate), the appropriately named fiduciary will consult with a health care professional who has proper training and experience in the relevant field of medicine. The health care professional reviewing the appeal will not be the person who was consulted in the initial adverse benefit determination or a subordinate of that person. The Plan Administrator shall identify any medical or vocational experts it consulted on behalf of the Plan regarding a claimant's adverse benefit determination, whether or not it relied upon their advice.

In an appeal of an adverse benefit determination of an urgent care claim, the claimant may request an expedited appeal orally or in writing. All necessary information, including the Plan's determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or any other available, similarly expeditious method.

FINAL DECISION

The Plan Administrator shall make a decision regarding a request for review as follows:

- A. **Urgent Care Claims.** The Plan Administrator shall notify the claimant of its determination on review of an urgent care claim within 72 hours after receipt of the claimant's request for a review of an adverse benefit determination.
- B. **Pre-Service Claims.** There shall be two levels of appeal for pre-service claims. The Plan Administrator shall notify the claimant of its determination regarding a first-level appeal within 15 days after receipt of the claimant's request for a

review of an adverse benefit determination. A claimant whose first level of appeal is denied may submit a second level appeal to the Plan Administrator in writing within 60 days following the denial of the first level appeal. If the claimant submits a second appeal, the Plan Administrator shall notify the claimant of its determination regarding a second-level appeal within 15 days after receipt of the claimant's request of a second-level review of an adverse benefit determination.

- C. Post-Service Claims. There shall be two levels of appeal for post-service claims. The Plan Administrator shall notify the claimant of its determination regarding a first-level appeal within 30 days after receipt of the claimant's request for a review of an adverse benefit determination. A claimant whose first level of appeal is denied may submit a second level appeal to the Plan Administrator in writing within 60 days following the denial of the first level appeal. If the claimant submits a second appeal, the Plan Administrator shall notify the claimant of its determination regarding a second-level appeal within 30 days after receipt of the claimant's request of a second-level review of an adverse benefit determination.

The Plan Administrator shall provide a claimant with written or electronic notification of its determination on review. The notice shall include the same information that was required in the notification of the initial adverse benefit determination. The decision of the Plan Administrator on appeal shall be final and binding.

SPECIAL RULES

In accordance with Health Care Reform, Covered Persons will be provided with the following additional rights with respect to claims and appeals:

- A. A claimant has the right to appeal an adverse benefit determination under the Plan, which includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. In addition, a rescission of coverage is considered an adverse benefit determination for this purpose. As a result, a claimant has the right to appeal a rescission of coverage under the Plan.
- B. In connection with the appeal of an adverse benefit determination, the claimant must be provided, free of charge, with 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 of the adverse benefit determination. Further, the claimant must be provided with a reasonable opportunity to respond to the new or additional evidence or rationale.
- C. The Plan cannot base decisions regarding the hiring, compensation, termination, or promotion of a claims adjudicator, medical expert, or similar individual upon the likelihood that the individual will support the Plan's denial of benefits.
- D. Certain benefit determination notices and appeal notices may be required to be provided in a language other than English if ten percent or more of the population

residing in the claimant's county are literate only in that other language. Further, the notices must include additional information such as information sufficient to identify the claim involved, the denial code and its corresponding meaning, any standard used in denying the claim, and a description of the available internal appeals and external review processes.

- E. The Legal Proceedings subsection states that no court action may be brought by a claimant until exhausting the Claims Procedure provisions of the Plan. If the Plan fails to strictly adhere to the internal claim and appeal procedures prescribed by Health Care Reform, the claimant is deemed to have exhausted the internal claim and appeal procedures. As a result, the claimant may initiate an external review and/or file a legal proceeding. However, this rule shall not apply to minor, de minimis violations.
- F. A Plan must offer an external review process. The Plan may be subject to the applicable state external review process for fully-insured health plans and non-ERISA self-funded health plans. Otherwise, the Plan will offer an external review procedure which satisfies U.S. Department of Labor regulations. Information about the external review process is as follows:
 - 1. The primary type of external review is a standard external review. A claimant must file a request for a standard external review within four months after the date of receipt of a notice of adverse benefit determination or final internal adverse benefit determination.
 - 2. Within five business days following the date of receipt of the external review request, the Plan must complete a preliminary review of the request to determine whether all of the following has occurred:
 - a. The claimant had coverage under the Plan at the time the service or supply was provided.
 - b. The claimant has exhausted the Plan's internal appeal process unless not required to do so as described above.
 - c. The claimant has provided all information and forms necessary to process the external review.
 - 3. Within one business day after completing the preliminary review, the Plan will issue a written notification to the claimant. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. In such case, the Plan will allow the claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

4. If the Plan determines that an adverse benefit determination or final internal adverse benefit determination is eligible for external review, the Plan shall assign the external review to an independent review organization (“IRO”) that is accredited by URAC or by a similar nationally recognized accrediting organization. The Plan shall take action against bias and to ensure independence. The Plan shall have contracts in place with at least three IROs, and external reviews shall be rotated among the IROs. In addition, an IRO shall not be eligible for any financial incentive based on the likelihood that the IRO will support the denial of benefits. The IRO shall follow the procedure below:
 - a. The assigned IRO will notify the claimant in writing of the request’s eligibility and acceptance for external review. In order to be eligible for external review, the adverse benefit determination or final internal adverse benefit determination must involve a medical judgment or rescission of coverage. The IRO shall make this determination when considering the request’s eligibility for external review. If accepted, the notice will include a statement that the claimant may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information for the IRO to consider when conducting the external review.
 - b. Within five business days after the date of the 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. 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 business day after making the decision, the IRO must notify the claimant and the Plan.
 - c. Upon any receipt of any information submitted by the claimant, the IRO must, within one 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. The external review may be terminated as a result of the reconsideration only if the Plan reverses its adverse benefit determination or final internal adverse benefit determination and provides coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO shall terminate the external review upon receipt of the notice from the Plan.

- d. The IRO will review all the information and documents timely received. In reaching a decision the assigned IRO will review the claim “de novo” (i.e., anew) and will not be bound by any decisions or conclusions reached during the Plan’s internal claims and appeals process. The IRO may also consider additional documents and information in conducting the external review, including the claimant’s medical records; the attending health care professional’s recommendation; reports from appropriate health care professionals; other documents submitted by the Plan, claimant, or claimant’s treating provider; the terms of the Plan; appropriate practice guidelines (including applicable evidence-based standards); any applicable clinical review criteria developed and used by the Plan, unless inconsistent with the terms of the Plan or applicable law; and the opinion of the IROs clinical reviewer(s).
 - e. The IRO must provide written notice of its final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of its final external review decision to the claimant and the Plan.
 - f. The IRO’s decision notice will contain a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date[s] 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), the date that the IRO received the assignment to conduct the external review, the date of the IRO decision, references to the evidence or documentation considered in reaching its decision, a discussion of the principal reason(s) for its decision, a statement that the determination is binding except to the extent that other remedies may be available under state or federal law, a statement that judicial review may be available, and current contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act.
 - g. After a final external review, the IRO must maintain records of all claims and notices associated with the external review for six years. The IRO must make such records available for examination by the claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.
5. Upon receipt of a notice of final external review reversing the adverse benefit determination or final internal adverse benefit determination, the Plan must immediately provide coverage or payment in connection with the claim.

6. The second type of external review is an expedited external review. The Plan must allow a claimant to make a request for an expedited external review in two situations. First, an expedited external review is available where the claimant has received an adverse benefit determination and it involves a medical condition of the claimant for which the time frame for completing an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited external appeal. Second, an expedited external review is available where the claimant has received a final internal adverse benefit determination and the claimant has a medical condition where the time frame for completing a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant'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 claimant received emergency services, but has not been discharged for a facility. The Plan and the IRO shall follow the procedure below for an expedited external review:
 - a. Immediately upon the receipt of a request for an expedited external review, the Plan must determine whether the request meets the review ability requirements set forth above for a standard external review. The Plan must immediately send a written notice that meets the requirements set forth above for a standard external review to the claimant regarding its eligibility determination.
 - b. Upon a determination that the request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for a standard external review. The Plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse determination to the assigned IRO electronically, by telephone, by facsimile, or by any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents under the same procedures for a standard external review. In reaching a decision, the IRO must review the claim "de novo" (i.e., anew) and is not bound by any decisions or conclusions reached during the Plan's internal claim and appeals process.
 - c. The IRO shall provide notice of its decision in the same manner as a standard external review and shall do so as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must

provide written confirmation of the decision to the claimant and the Plan.

LEGAL PROCEEDINGS

No action at law or in equity shall be brought by a claimant to recover a claim on the Plan before the exhaustion of remedies provided under the Claims Procedure provisions of the Plan, nor shall such action be brought at all, unless brought by the last day of the Plan Year after the Plan Year in which the claimant was provided with a written notice denying the final level of Plan appeal concerning the claim.

NO INTEREST

The Plan shall not be required to pay interest on any claim for Plan benefits regardless of when paid.

ESCHEAT

If a check for the payment of Plan benefits is not negotiated within one year after the date it is issued, the check shall be dishonored.

COMPLIANCE WITH HIPAA PRIVACY AND SECURITY RULES

PERMITTED AND REQUIRED USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Subject to obtaining written certification pursuant to the Certification of the Plan Sponsor provision (see below), the Plan may disclose PHI to the Plan Sponsor, provided that the Plan Sponsor does not use or disclose that PHI except for the following purposes:

- A. To perform Administrative Functions for the Plan.
- B. To obtain premium bids from insurance companies or other health plans for providing coverage under or on behalf of the Plan.
- C. To modify, amend, or terminate the Plan.

Notwithstanding the provisions of the Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner inconsistent with 45 CFR § 164.504(f).

CONDITIONS OF DISCLOSURE

The Plan Sponsor agrees to the following in regard to any PHI:

- A. To not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

- B. To ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.
- C. To not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan.
- D. To report to the Plan any known use or disclosure of the information that is inconsistent with the uses or disclosures permitted.
- E. To make a Covered Person's PHI available when he or she requests access in accordance with 45 CFR § 164.524.
- F. To make a Covered Person's PHI available when he or she requests an amendment to same, and to incorporate any amendments to that PHI in accordance with 45 CFR § 164.526.
- G. To make available the information required to provide an accounting of disclosures of PHI to a Covered Person upon request in accordance with 45 CFR § 164.528.
- H. To make its internal practices, books, and records relating to the use and disclosures of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services in order to determine compliance by the Plan with the HIPAA privacy rules.
- I. To return or destroy all PHI received from the Plan if the PHI is still maintained in any form, if feasible, and to retain no copies of such information when no longer needed for the purpose for which the disclosure was made. If 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.
- J. To ensure that the adequate separation between the Plan and the Plan Sponsor, required in 45 CFR § 164.504(f)(2)(iii), is satisfied and that terms set forth in the applicable provision below are followed.

To be compliant with the HIPAA security standards, the Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/termination information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, the Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI. The Plan Sponsor shall ensure that any agents (including Business Associates and subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The Plan Sponsor shall report to the Plan any security incident of which it becomes aware.

CERTIFICATION OF PLAN SPONSOR

The Plan shall disclose PHI to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth above.

PERMITTED USES AND DISCLOSURE OF SUMMARY HEALTH INFORMATION

The Plan may disclose Summary Health Information to the Plan Sponsor provided that the Plan Sponsor uses such Summary Health Information only for the following purposes:

- A. To obtain premium bids from health plan providers to provide health coverage under the Plan.
- B. To modify, amend, or terminate the Plan.

ADEQUATE SEPARATION BETWEEN THE PLAN AND THE PLAN SPONSOR

The Plan Sponsor will provide access to PHI to the employees or classes of employees listed in its HIPAA privacy policies and procedures. The Plan Sponsor will restrict the access to and use of PHI by these individuals to the Administrative Functions that the Plan Sponsor performs for the Plan. In the event any of these individuals do not comply with the provisions of the Plan relating to use and disclosure of PHI, the Plan Sponsor will impose reasonable sanctions as necessary, in its discretion, to ensure that no further noncompliance occurs. The Plan Sponsor will impose such sanctions progressively (e.g., an oral warning, a written warning, time off without pay, and termination), if appropriate, and commensurate with the severity of the violation.

To comply with the HIPAA security rule, the Plan Sponsor shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the authorized employees or classes of employees have access to electronic PHI.

DISCLOSURE OF CERTAIN ENROLLMENT INFORMATION

Pursuant to 45 CFR § 164.504(f)(1)(iii), the Plan may disclose information on whether an individual is enrolled in or has terminated from the Plan to the Plan Sponsor.

DISCLOSURE OF PHI TO OBTAIN STOP-LOSS OR EXCESS LOSS COVERAGE

In accordance with the HIPAA privacy rules, the Plan Sponsor authorizes and directs the Plan to disclose PHI to stop-loss carriers, excess-loss carriers, or managing general underwriters for underwriting and other purposes in order to obtain and maintain stop-loss or excess-loss coverage related to benefit claims under the Plan.

OTHER USES AND DISCLOSURES OF PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the HIPAA privacy rules.

HYBRID ENTITY

This provision only applies to the extent to which the Plan provides any non-health benefits such as (but not limited to) disability benefits or group term life insurance benefits. The Plan is a separate legal entity whose business activities include functions covered by the HIPAA privacy rules as well as functions not covered by those rules. As a result, the Plan is a “hybrid entity” as that term is defined in the HIPAA privacy rules. The Plan’s covered functions are its health benefits (“health care component”). All other benefits are non-covered functions. Therefore, the Plan hereby designates that it shall only be a covered entity under the HIPAA privacy rules with respect to the health care component (the health benefits) of the Plan.

PARTICIPANT NOTIFICATION

Participants shall be notified of the Plan’s compliance with the HIPAA privacy rules in a Notice of Privacy Practices.

PLAN ADMINISTRATOR

The Plan Administrator is charged with the administration of the Plan. The Plan Administrator shall have the discretionary authority to decide all questions of eligibility for participation and eligibility for benefit payments and to determine the amount and manner of payment of benefits. The Plan Administrator shall exercise its discretion in a uniform and consistent manner, based upon the objective criteria set forth in the Plan. Further, the Plan Administrator shall have the discretionary authority to construe and interpret the terms of the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions. The Plan Administrator may delegate all or a portion of its duties under the Plan to one or more authorized officers and/or an administrative committee.

AMENDMENTS AND TERMINATION

The Plan Sponsor reserves the right to amend or terminate this Plan at any time, in compliance with the following provisions:

- A. The Plan Sponsor shall have the right to amend this Plan at any time, in whole or in part, to take effect retroactively or otherwise. No amendment may retroactively reduce claims for any Covered Expenses that were incurred before the amendment unless necessary to conform the Plan to the requirements of the Code, regulations issued under those statutes, and any other applicable laws or regulations.
- B. The Plan Sponsor reserves the right at any time to terminate the Plan by action of the Board of Directors or other similar governing body of the Plan Sponsor.

In addition, the Plan shall automatically terminate upon the occurrence of any of the following events:

- A. The liquidation or discontinuance of the business of the Plan Sponsor.
- B. The adjudication of the Plan Sponsor as bankrupt.
- C. A general assignment by the Plan Sponsor to or for the benefit of one or more of its creditors.
- D. The merger or consolidation of the Plan Sponsor to another entity that is the surviving entity.
- E. The consolidation or reorganization of the Plan Sponsor.
- F. The sale of substantially all of the assets of the Plan Sponsor, unless the successor or purchasing entity adopts the Plan within 90 days thereafter.

If termination occurs, the Plan shall pay all benefits for Covered Expenses incurred before the termination date. Covered Persons shall have no further rights under the Plan.

MISCELLANEOUS

FREE CHOICE OF PHYSICIAN

The Covered Person shall have free choice of any legally qualified Physician or surgeon.

WORKERS' COMPENSATION NOT AFFECTED

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

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law or regulation to which it is subject, that provision is deemed amended to conform to such law or regulation.

FAILURE TO ENFORCE

Failure to enforce any provision of this Plan does not constitute a waiver or otherwise affect the Plan Administrator's right to enforce such a provision at any other time, nor will such failure affect the right to enforce any other provision.

ENTIRE REPRESENTATION / NO ORAL MODIFICATIONS

This single document sets forth the terms of the Plan and the Summary Plan Description and it supersedes all other documents. Any other descriptive or interpretive materials (such as benefit summaries) shall not change the terms of the Plan as set forth in this document. Further, the terms of the Plan may not be modified by any oral statements made by the Employer or any of its

directors, officers, Employees, agents, or authorized representatives, including, but not limited to, the Claim Administrator.

NO VESTING

There is no vested right to current or future benefits under this Plan. A Covered Person's right to benefits is limited to any Plan assets and to Covered Expenses incurred and submitted within the time limits set forth in the Claims Procedure provision and incurred and submitted before the earliest of the following:

- A. An amendment to the Plan that limits or terminates such benefits.
- B. Termination of the Plan.
- C. Termination of coverage or participation.

NON-ASSIGNABILITY

The benefits payable under the Plan to a Covered Person are specific to the Covered Person and may be received only by the Covered Person. No benefits of the Plan shall be assigned to any person, corporation, entity, or party except for assignment to the federal government in accordance with back-up withholding laws or except as provided in accordance with any assignment of rights as required by a state Medicaid program and in accordance with any state law that provides that the state has acquired the rights to payment with respect to a Covered Person. Any other attempted assignment shall be void. However, the Plan reserves the right to make payment of benefits, in its sole discretion, directly to a provider of services or the Covered Person. The Plan reserves the right, in its sole discretion, to refuse to honor the assignment of any claim to any person, corporation, entity, or party. This section shall not be interpreted to prevent direct billing for Covered Expenses by a provider to the Plan Administrator.

NO EMPLOYMENT RIGHTS

The establishment and maintenance of this Plan shall not be construed as conferring any legal rights on any Employee to be continued in the employ of the Employer, nor shall this Plan interfere in any way with the right of the Employer to discharge any Employee.

COVERED PERSONS' RIGHTS

Except as may be required by law, the establishment of this Plan and the Trust, if any, shall not be construed as giving any Participant or Dependent any equity or other interest in the assets, business, or affairs of the Employer; or the right to question or complain about any action taken by its officers, directors, or stockholders or about any policy adopted or followed by the Employer; or the right to examine any of the books and records of the Employer. The rights of all Participants and Dependents shall be limited to their right to receive payment of their benefits from the Plan when the same becomes due and payable in accordance with the terms of the Plan.

ACTS OF PROVIDERS

Nothing contained in this Plan shall confer upon a Covered Person any claim, right, or cause of action, either at law or in equity, against this Plan for the acts of any provider (e.g., Hospital, Physician, nurse, pharmacist, etc.) from which the Covered Person receives services or care while covered under this Plan.

RECOVERY OF OVERPAYMENT

If the Plan pays benefits that should not have been paid under the Plan or pays benefits in excess of what should have been paid under the Plan, the Plan Administrator shall have the right to recover such payment or excess from any individual, insurance company, or other third-party payer, provider, or any other organization to or for whom the payment was made. Recovery may be in the form of an offset against future amounts owed under the Plan, by a lump-sum refund payment, or by any other method as the Plan Administrator, in its sole discretion, may require.

ACCEPTANCE / COOPERATION

Accepting benefits under the Plan means that the Covered Person has accepted the Plan's terms and shall be obligated to cooperate with the Plan Administrator's requests to help protect the Plan's rights and carry out its provisions.

DEFINITIONS

Certain words and phrases used in this Plan are listed below, along with the definition or explanation of the manner in which the term is used for the purposes of this Plan. Where these terms are used elsewhere in the Plan with the meanings assigned to them below, the terms usually will be capitalized, and where these terms are used with their common, non-technical meanings, the terms usually will not be capitalized (except when necessary for proper grammar).

ACCIDENT; ACCIDENTAL

The term "Accident" or "Accidental" means a bodily Injury sustained independently of all other causes that is sudden, direct, and unforeseen, and is exact as to time and place. Lifting, bending, stooping, simple exertion, etc., are not, in themselves, Accidental events.

ACTIVE EMPLOYEE; ACTIVE EMPLOYMENT

The term "Active Employee" or "Active Employment" means the Participant is Actively at Work.

ACTIVELY AT WORK

The term "Actively at Work" means the active expenditure of time and energy in the service of the Employer. A Participant shall be deemed Actively at Work on each day of a regular paid vacation and on a regular non-working day on which the Participant is not Totally Disabled, if the Participant was Actively at Work on the last preceding regular working day.

ADDICTIONS TREATMENT (ALCOHOLISM, DRUG ABUSE, OR SUBSTANCE ABUSE)

The term “Addictions Treatment” means the diagnosis, care, and treatment of alcoholism, drug abuse, or substance abuse (the taking of alcohol or other drugs or substances at dosages that place a Covered Person’s welfare at risk and cause the Covered Person to endanger the public welfare).

ADMINISTRATIVE FUNCTIONS

The term “Administrative Functions” means activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. Administrative Functions include quality assurance, employee assistance, claims processing, auditing, monitoring, and management of carve-out-benefits, such as vision and dental. PHI for these purposes may not be used by or between the Plan or Business Associates in a manner inconsistent with the HIPAA privacy rules, absent an authorization from the individual. Administrative functions specifically do not include any employment-related functions.

ANNUAL OPEN ENROLLMENT PERIOD

The term “Annual Open Enrollment Period” means the period during the year for making elections under the Plan. The beginning and ending dates of each Annual Open Enrollment Period shall be determined by the Employer and communicated to Participants.

BEHAVIORAL CARE

The term “Behavioral Care,” also known as psychoanalytic care or psychiatric care, means treatment for a Mental Illness or Disorder, a Functional Nervous Disorder, or for Addictions Treatment.

BIRTHING CENTER

The term “Birthing Center” means a facility that meets all of the following criteria:

- A. Is licensed as a Birthing Center by the appropriate jurisdiction.
- B. Is set-up, equipped, and run solely as a setting for prenatal care, delivery, and immediate postpartum care.
- C. Charges fees for the services and supplies that it provides.
- D. Is under the direction of at least one M.D. or D.O. specializing in obstetrics and gynecology.
- E. Has an M.D. or D.O. present at all births and during the immediate postpartum period.
- F. Extends staff privileges to Physicians who have privileges to provide obstetrical and gynecological care in an area Hospital.

- G. Has a minimum of two beds or two birthing rooms for patients in labor and during delivery.
- H. Provides, in the delivery and recovery room, full-time skilled nursing services under the direction of Registered Nurses (R.N.s).
- I. Has diagnostic X-ray and laboratory equipment necessary to perform tests on the mother and the Newborn.
- J. Has equipment and supplies necessary to perform surgery, including episiotomy and repair of perineal tear, and to administer a local anesthetic.
- K. Has equipment and trained personnel necessary to deal with medical emergencies; is able to provide immediate support measures to sustain life for complications arising during labor or for Newborns with abnormalities that impair function or threaten life.
- L. Has an admission policy for accepting only patients with low-risk Pregnancies.
- M. Has a written agreement with an area Hospital for immediate transfer in case of emergency; displays written procedures for such a transfer and ensures that the staff is aware of these procedures.
- N. Provides an ongoing quality assurance program with reviews by M.D.s or D.O.s other than those who own, direct, or are employed by the Birthing Center.
- O. Keeps written and comprehensive medical records on each patient admitted to, and each infant born at, the Birthing Center.

BUSINESS ASSOCIATE

The term “Business Associate” means a person or entity who does the following:

- A. Performs or assists in performing a Plan function or activity involving the use and disclosure of PHI (including claims processing or administration, data analysis, underwriting, etc.).
- B. Provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.

CALENDAR YEAR

The term “Calendar Year” means a period of time beginning with January 1 and ending on the following December 31.

CERTIFIED REGISTERED NURSE ANESTHETIST

The term “Certified Registered Nurse Anesthetist” means an individual who has received specialized nurse-anesthetist training, is authorized to use the designation of “C.R.N.A.,” and is

duly licensed by the state or regulatory agency responsible for licensing in the state in which the individual performs nurse-anesthetist services.

CHANGE IN STATUS

The term “Change in Status” means any of the following:

- A. An event that changes the Employee’s legal marital status, including marriage, death of the Employee’s spouse, divorce, legal separation (if recognized by the state in which the individuals reside), and annulment.
- B. An event that changes the number of an Employee’s dependents, including birth, adoption, placement for adoption, and death of a dependent.
- C. An event affecting the employment status of the Employee, the Employee’s spouse, or the Employee’s dependent; including termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence, a change in work site, and any other change in employment status that affects an individual’s eligibility for benefits.
- D. An event that causes an Employee’s dependent to satisfy or cease to satisfy the requirement(s) for coverage owing to the attainment of a specified age, student status, or any similar circumstance.
- E. A change in the place of residence of the Employee, the Employee’s spouse, or the Employee’s dependent.

CLAIM ADMINISTRATOR

The term “Claim Administrator” means the person or firm, if any, retained by the Plan Administrator to handle the processing, payment, and settlement of benefit claims and other duties specified in a written administration agreement. If there is no Claim Administrator (for any reason, including circumstances caused by the termination or expiration of the Administration Agreement with the initial Claim Administrator), or if the term is used in connection with a duty not expressly assumed by the Claim Administrator in a signed writing, the term shall mean the Plan Administrator.

CLOSE RELATIVE

The term “Close Relative” means the spouse, parent, brother, sister, child, or in-laws of a Covered Person.

COBRA

The term “COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (see Section 4980B of the Code and Sections 601 *et seq.* of the Employee Retirement Income Security Act of 1974 [ERISA], as amended). See Consolidated Omnibus Budget Reconciliation Act of 1985.

CODE

The term “Code” means the Internal Revenue Code of 1986, as amended.

COINSURANCE

The term “Coinsurance” means a Covered Person’s share of the cost of a Covered Expense. Coinsurance is expressed as a percentage (for example, 20%) and typically applies after the Deductible (if any) has been satisfied.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

The term “Consolidated Omnibus Budget Reconciliation Act of 1985” means federal legislation that gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances. In the context of a governmental employer, this term means the parallel continuation coverage provisions of the Public Health Service Act. See COBRA.

CONVALESCENT NURSING FACILITY

The term “Convalescent Nursing Facility” means an institution, or a distinct part of an institution, that is operated pursuant to law and meets all of the following conditions:

- A. It is licensed to provide, and is engaged in providing, for persons convalescing from Injury or Illness on an Inpatient basis, professional nursing services rendered by a Registered Nurse, or by a Licensed Practical Nurse under the direction of a Registered Nurse, and physical restoration services to assist patients to reach a degree of bodily functioning to permit self-care in essential daily living activities.
- B. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or Registered Nurse.
- C. It maintains a complete medical record on each patient.
- D. It has an effective utilization review plan.
- E. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, persons with developmental or learning disabilities, custodial or educational care, or care of mental disorders.

This term shall also apply to expenses incurred in an institution referring to itself as a skilled nursing facility, extended care facility, convalescent nursing home, or any other similar nomenclature.

CONVALESCENT PERIOD

The term “Convalescent Period” means a period of time beginning with the date of confinement by the Covered Person to a Convalescent Nursing Facility. The confinement must meet both of the following conditions:

- A. The confinement must have been for a period of at least three consecutive days.
- B. The convalescent confinement must begin within 14 days after the Covered Person is discharged from a Hospital, and both the Hospital and convalescent confinements must have been for the care and treatment of the same Illness or Injury; or, the convalescent confinement must be as an alternative to hospitalization. The Plan Administrator may require that a Physician certify whether the convalescent care is rendered as an alternative to hospitalization.

A Convalescent Period will terminate when the Covered Person has been free of confinement for a period of 90 consecutive days in any and all institutions providing hospital or nursing care. A Convalescent Period may be extended if approved as Medically Necessary by the Utilization Review Firm.

COSMETIC PROCEDURE

The term “Cosmetic Procedure” means any procedure that is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness, Injury, or disease.

COVERED EXPENSES

The term “Covered Expenses” means expenses incurred by a Covered Person for any Medically Necessary treatments, services, or supplies that are not specifically excluded from coverage elsewhere in this Plan. Covered Expenses are incurred on the date that any Medically Necessary treatments, services, or supplies are provided to a Covered Person.

COVERED PERSON

The term “Covered Person” means any person meeting the eligibility requirements for coverage as specified in this Plan and who is properly enrolled in the Plan. This term includes Participants and their eligible Dependents.

CUSTODIAL CARE

The term “Custodial Care” means that type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist a Covered Person, whether or not Totally Disabled, in the activities of daily living. Activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication that can normally be self-administered.

DEDUCTIBLE

The term “Deductible” means a specified dollar amount of Covered Expenses that must be incurred during a year before any other Covered Expenses can be considered for payment at the percentages stated in the Schedule of Benefits and in this Plan.

DEPENDENT

The term “Dependent” means the following:

- A. The Participant’s legal spouse who is a resident of the same country in which the Participant resides. The spouse must have met all of the requirements of a valid marriage contract in the state of marriage of the parties.
- B. A child who meets all of the following conditions:
 - 1. May be identified in one of the following categories:
 - a. The Participant’s natural child, the Participant’s stepchild, the Participant’s legally adopted child, or a child who is being placed for adoption with the Participant.
 - b. A child who is under the legal guardianship of the Participant and could be considered a “dependent” of the Participant for tax exemption purposes under Section 152 of the Code.
 - c. A child to whom the Participant is obligated to provide medical care coverage under an order or judgment of a court of competent jurisdiction and could be considered a “dependent” of the Participant for tax exemption purposes under Section 152 of the Code.
 - 2. Is less than 26 years of age. Coverage will continue through the end of the month in which the child’s 26th birthday occurs. The age requirement above is waived for any child who is developmentally disabled or who has a physical handicap(s) before age 26 who is incapable of self-sustaining employment, and who could be considered a “dependent” of the Participant for tax exemption purposes under Section 152 of the Code. Proof of incapacity must be furnished to the satisfaction of the Plan Administrator upon request, and the Plan Administrator may request additional proof from time to time.
- C. A child for whom the Participant is obligated to provide medical coverage under a QMCSO, notwithstanding the above.

NOTE: If both parents are Employees of the Employer, children will be covered under this Plan as Dependents of only one parent.

The Participant may be asked to certify the status of the persons for whom the Participant is claiming Dependent status, and benefits shall be terminated and the Participant shall be asked to reimburse the Plan if it is discovered that he/she has provided false information.

The term “Dependent” excludes these situations:

- A. A spouse or former spouse who is legally separated or divorced from the Participant, pursuant to a valid separation or divorce in the state granting the separation or divorce.
- B. Any person who is covered under this Plan as an individual Participant.
- C. Any person who would otherwise qualify as a Dependent, but who is not properly enrolled in the Plan.

DEPENDENT COVERAGE

The term “Dependent Coverage” means coverage under the Plan for benefits payable as a consequence of an Illness or Injury of a Dependent or, if allowable under the Plan, for Routine preventive care for a Dependent.

DURABLE MEDICAL EQUIPMENT

The term “Durable Medical Equipment” means equipment that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful for a person in the absence of Illness or Injury.

Modifications to houses or vehicles, including, but not limited to, platform lifts, stair lifts, stairway elevators, wheelchair lifts or ramps, and ceiling lifts are not considered Durable Medical Equipment and are not covered under the Plan.

EMPLOYEE

The term “Employee” means a common-law employee of the Employer. An independent contractor is not an Employee. Further, a leased employee within the meaning of Code Section 414(n) is not an Employee. If an independent contractor or a leased employee is subsequently characterized as a common-law employee of the Employer, that person shall not be eligible to participate in the Plan for any time period before the date on which the determination is made that that person is a common-law employee of the Employer.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

The term “Employee Retirement Income Security Act of 1974” means a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. See ERISA.

EMPLOYER

The term “Employer” means **DETROIT ACADEMY OF ARTS & SCIENCES**. The term “Employer” shall also include **ACADEMY MANAGEMENT COMPANY**, a related employer participating in the Plan. However, for purposes of performing the duties of the Plan Sponsor and Plan Administrator, “Employer” means **DETROIT ACADEMY OF ARTS & SCIENCES**.

The term “Employer” shall not include any offices or locations of the Employer located outside of the United States, nor any commonly owned entities or foreign subsidiaries of the Employer located outside of the United States. Eligibility for Plan coverage shall not be conferred upon employees of such offices, locations, or commonly owned foreign entities and subsidiaries unless specifically stated otherwise elsewhere in the Plan.

ERISA

The term “ERISA” refers to the Employee Retirement Income Security Act of 1974, as amended, Section 3(1), 29 U.S.C. §1002(1). See Employee Retirement Income Security Act of 1974.

ESSENTIAL HEALTH BENEFIT

The term “Essential Health Benefit” has the meaning set forth by Health Care Reform. A list of Essential Health Benefits can be viewed by logging on to the Claim Administrator’s Website address printed on the back of the Covered Person’s identification card.

EXPERIMENTAL; INVESTIGATIONAL

The term “Experimental” or “Investigational” means a drug, device, medical treatment, or procedure (other than a covered Off-Label Use) that meets any of the following criteria:

- A. The U.S. Food and Drug Administration (FDA) must approve the lawful marketing of the drug, device, treatment, or procedure, and the FDA gave no such approval when initially receiving the drug, device, treatment, or procedure.
- B. A patient informed consent document utilized with the drug, device, treatment, or procedure was reviewed and approved by the treating facility’s Institutional Review Board or other body serving a similar function, or federal law requires such review or approval.
- C. The drug, device, medical treatment, or procedure is shown by Reliable Evidence to be any of the following:
 1. The subject of ongoing Phase I or Phase II clinical trials.
 2. The research, experimental, study, or investigational arm of ongoing Phase III clinical trials.
 3. Otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

- D. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

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

Off-Label Use shall not be considered Experimental or Investigational where all of the following requirements are satisfied:

- A. The drug, device, medical treatment, or procedure is otherwise a Covered Expense under the Plan.
- B. The drug, device, medical treatment, or procedure has been approved by the FDA.
- C. The Off-Label Use of the drug, device, medical treatment, or procedure has been recognized for treatment of the condition for which it is prescribed by one of the following:
1. Micromedex[®] DRUGDEX[®] (Micromedex[®] and DRUGDEX[®] are registered trademarks of Truven Health Analytics).
 2. The American Hospital Formulary Service Drug Information.
 3. Formal clinical studies, the results of which have been published in at least two peer-reviewed professional journals published in the United States or Great Britain.
 4. Standard reference compendia or substantially accepted peer-reviewed medical literature.

FAMILY

The term “Family” means a Participant and any Dependent(s).

FAMILY AND MEDICAL LEAVE ACT OF 1993

The term “Family and Medical Leave Act of 1993” means a federal law that provides certain employees with unpaid, job-protected leave each year, the duration of which is pre-determined by the federal government. It also requires that their group health benefits be maintained during the leave. See FMLA.

FMLA

The term “FMLA” means the Family and Medical Leave Act of 1993, Public Law 103-3 (February 5, 1993), 107 Stat. 6 (29 U.S.C. 2601 et seq.). See Family and Medical Leave Act of 1993.

FULL-TIME EMPLOYMENT

The term “Full-Time Employment” means a basis by which a Participant is employed and is compensated for services by the Employer for at least the number of hours per week stated in the eligibility requirements of the Schedule for Eligibility and Participation. The work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Participant to travel. A full-time Employee who is absent from work because of a health condition is considered to work in Full-Time Employment for purposes of satisfying any waiting period set forth in the eligibility requirements of the Schedule for Eligibility and Participation.

HEALTH CARE REFORM

The term “Health Care Reform” refers to the collective body of legislation that originated with the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA) and grew to include any later laws that amend either of those Acts directly or indirectly, in whole or in part.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The term “Health Insurance Portability and Accountability Act of 1996” means a federal law that limits the use of pre-existing condition exclusions, waiting periods, and health status exclusions; eliminates certain discriminatory exclusions, such as for self-inflicted injuries; and promulgates administrative simplification provisions. See HIPAA.

HIPAA

The term “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended (Public Law 104-191). See Health Insurance Portability and Accountability Act of 1996.

HOME HEALTH CARE AGENCY

The term “Home Health Care Agency” means a public or private agency or organization that specializes in providing medical care and treatment in the home. This type of provider must meet all of the following conditions:

- A. It is primarily engaged in providing skilled nursing services and other therapeutic services and is duly licensed, if such licensing is required, by the appropriate licensing authority.
- B. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one Physician and at

least one Registered Nurse to govern the services provided, and it must provide for full-time supervision of such services by a Physician or Registered Nurse.

- C. It maintains a complete medical record on each individual.
- D. It has a full-time administrator.

HOSPICE

The term “Hospice” means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel that includes at least one Physician and one Registered Nurse, and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

HOSPICE BENEFIT PERIOD

The term “Hospice Benefit Period” means a specified amount of time during which the Covered Person undergoes treatment by a Hospice. This time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminally ill and the Covered Person is accepted into a Hospice program. The earliest that the period shall end is six months from this date or at the death of the Covered Person. A new Hospice Benefit Period may begin if the attending Physician certifies that the patient is still terminally ill. However, the Plan Administrator may require additional proof before such a new Hospice Benefit Period can begin.

HOSPITAL

The term “Hospital” means an institution that meets all of the following conditions:

- A. It is primarily engaged in providing medical care and treatment to Ill and Injured persons on an Inpatient basis at the patient’s expense.
- B. It is constituted, licensed, and operated in accordance with the laws that pertain to hospitals of the jurisdiction in which it is located.
- C. It maintains on its premises all of the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or an Injury, unless it is a Behavioral Care, Addictions Treatment, or rehabilitation hospital.
- D. Treatment is provided for compensation by or under the supervision of Physicians, with continuous 24-hour nursing services by Registered Nurses.
- E. It qualifies as a hospital, a Behavioral Care hospital, or a tuberculosis hospital and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association (AOA), the Commission on Accreditation of Rehabilitation Facilities (CARF), or DNV Healthcare, Inc. (DNV). If the Centers for Medicare and Medicaid Services has

designated the facility as a critical access hospital, the JCAHO, AOA, CARF, or DNV accreditation requirement will be waived.

- F. It is not, other than incidentally, a nursing home or a place for rest, the aged, drug addicts, or alcoholics.

ILLNESS

The term “Illness” means a bodily disorder, disease, physical sickness, mental infirmity, Functional Nervous Disorder, or Pregnancy of a Covered Person. A recurrent Illness will be considered one Illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All disorders existing simultaneously that are caused by the same or related causes shall be considered one Illness.

INJURY

The term “Injury” means a localized, abnormal condition of the body, internal or external, traumatically induced.

IN-NETWORK PROVIDERS

The term “In-Network Providers” means a group of Physicians, Hospitals, and other medical providers that have agreed to provide health care at discounted fees in accordance with the “Utilization of In-Network Providers Benefit.”

INPATIENT

The term “Inpatient” refers to the classification of a Covered Person when that person is admitted to a Hospital, Hospice, or Convalescent Nursing Facility for treatment, and charges are made for Room and Board to the Covered Person as a result of such treatment.

INTENSIVE CARE UNIT

The term “Intensive Care Unit” means a section, ward, or wing within the Hospital that is separated from other facilities and meets the following criteria:

- A. Is operated exclusively for the purpose of providing professional medical treatment for patients who have a critical Illness or Injury.
- B. Has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use.
- C. Provides constant observation and treatment by Registered Nurses or other highly trained Hospital personnel.

LICENSED PRACTICAL NURSE

The term “Licensed Practical Nurse” means an individual who is trained in basic nursing techniques and direct patient care, practices under the supervision of a Registered Nurse, is

authorized to use the designation of “L.P.N.,” and is duly licensed by the state or the regulatory agency in the state in which the individual performs these nursing services.

LIFETIME

The term “Lifetime” means the time a person is actually a Covered Person in this Plan, including any amendment or restatement of this Plan. The term “Lifetime” is not intended to suggest benefits before the effective date of an individual or after the termination of an individual or of the Plan.

MEDICALLY NECESSARY

The term “Medically Necessary” means a service, medicine, or supply that satisfies the requirements described in this section.

- A. Requirements. A service, medicine, or supply is Medically Necessary if it satisfies all of the following requirements:
1. It must be Usual and Customary for the diagnosis and treatment of an Illness or Injury.
 2. It must be legal.
 3. It must be ordered by a Physician or Physician’s Assistant. However, the fact that a service, medicine, or supply is ordered by a Physician or Physician’s Assistant does not mean that the service, medicine, or supply is Medically Necessary.
 4. It must be commonly and customarily recognized throughout the Physician’s profession as appropriate in treating the diagnosed Illness or Injury.
 5. It must be provided at an appropriate level of care to treat the diagnosed Illness or Injury.
- B. Exclusions. Services, medicines, or supplies that are not Medically Necessary shall include, but shall not be limited to, the following items:
1. Procedures that are of unproven value or of questionable current usefulness.
 2. Procedures that tend to be repetitive when performed in combination with other procedures.
 3. Diagnostic procedures that are unlikely to provide a Physician with additional information when they are used repeatedly.
 4. Procedures that are not ordered by a Physician or Physician’s Assistant or that are not documented in the patient’s medical records.

5. Services, medicines, and supplies furnished for the personal comfort or convenience of the patient.

A determination that a service, medicine, or supply is not Medically Necessary may apply to all or a portion of the service, medicine, or supply. The Plan Administrator, in its sole discretion, shall make the final determination as to whether a service, medicine, or supply is Medically Necessary.

MEDICARE

The term “Medicare” means the programs established by Title I of Public Law 89-98, as amended, entitled “Health Insurance for the Aged Act,” and that includes parts A and B of Subchapter XVIII of the Social Security Act as amended from time to time.

MENTAL ILLNESS OR DISORDER AND FUNCTIONAL NERVOUS DISORDER

The term “Mental Illness or Disorder and Functional Nervous Disorder” means mental, psychoneurotic, or personality disorders.

MOTOR VEHICLE

The term “Motor Vehicle” means a car or other vehicle, including a trailer, operated or designed for operation upon a public highway by power other than muscular power that has more than two wheels. Motor Vehicle does not include a motorcycle, a moped, or any “off-road vehicle” (ORV) or “all-terrain vehicle” (ATV).

NEWBORN

The term “Newborn” means an infant from the date of the infant’s birth until the initial Hospital discharge or until the infant is 14 days old, whichever occurs first.

NURSE PRACTITIONER; NURSE CLINICIAN; CLINICAL NURSE SPECIALIST

The terms “Nurse Practitioner,” “Nurse Clinician,” and “Clinical Nurse Specialist” mean a Registered Nurse who has been trained in an accredited program and is certified by an appropriate board to perform certain of a Physician’s duties, who is acting within the scope of his or her license, and who is under the supervision of a licensed Physician. The term “Nurse Practitioner” shall include Nurse Clinicians and Clinical Nurse Specialists whenever that term is used in the Plan.

Services provided by a Nurse Practitioner, Nurse Clinician, or Clinical Nurse Specialist will be considered to be Covered Expenses under the Plan, based on all Plan provisions, limitations, and requirements.

NURSE-MIDWIFE

The term “Nurse-Midwife” means a person who is certified or licensed and insured in accordance with the laws of the state in which care and delivery occur, and who is acting within the scope of his or her license while providing services.

OBESITY

The term “Obesity” means the physical state in which excess fat is stored at various sites in the body or an increase in body weight beyond the limitations of skeletal and physical requirements. A body weight that is 20% over the average weight given in standard height/weight tables is indicative of Obesity.

Morbid Obesity is indicated by a body weight that is 100% over the average weight given in standard tables.

OBRA 1993

The term “OBRA 1993” means the Omnibus Budget Reconciliation Act of 1993, Public Law 103-66 (August 10, 1993). See Omnibus Budget Reconciliation Act of 1993.

OCCUPATIONAL THERAPY

The term “Occupational Therapy” means the use of purposeful activity with individuals who are limited by physical Injury or Illness to assist in their rehabilitation and to restore normal function after an Injury or Illness. The practice encompasses evaluation, treatment, and consultation. Psychosocial dysfunction, developmental or learning disabilities, socioeconomic differences, and the aging process are excluded from this definition.

OFF-LABEL USE

The term “Off-Label Use” means the use of a drug, device, medical treatment, or procedure for a purpose other than that for which it was approved by the U.S. Food and Drug Administration (FDA).

OMNIBUS BUDGET RECONCILIATION ACT OF 1993

The term “Omnibus Budget Reconciliation Act of 1993” means a federal law that adds a provision to COBRA’s tax code rules regarding pediatric vaccine coverage. See OBRA 1993.

ORTHOPTICS; VISION THERAPY

The terms “Orthoptics” and “Vision Therapy” mean the science of correcting defects in a person’s simultaneous use of both eyes (binocular vision) through administration of vision therapy aids and/or eye muscle exercises.

ORTHOTIC OR PROSTHETIC APPLIANCE

The term “Orthotic or Prosthetic Appliance” means an internal or external device or structure intended to correct any defect in form or function of the human body.

OUT-OF-NETWORK PROVIDERS

The term “Out-of-Network Providers” means a group of Physicians, Hospitals, and other medical providers that do not participate within a plan’s contracted network and do not provide health care at discounted fees.

OUTPATIENT

The term “Outpatient” refers to the classification of a Covered Person when that Covered Person receives medical care, treatment, services, or supplies at a clinic, a Physician’s office, a Hospital (if not a registered bed patient at that Hospital), an Outpatient Behavioral Care Facility, or an Outpatient Addictions Treatment Facility.

OUTPATIENT ADDICTIONS TREATMENT FACILITY

The term “Outpatient Addictions Treatment Facility” means an institution that meets the following criteria:

- A. Provides a program for diagnosis, evaluation, and effective treatment of alcoholism, drug abuse, or substance abuse.
- B. Provides detoxification services necessary to its effective treatment program.
- C. Provides infirmatory-level medical services or arrangements at a Hospital in the area for any other medical services that may be required.
- D. Is at all times supervised by a staff of Physicians.
- E. Provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Nurse.
- F. Prepares and maintains a written plan of treatment for each patient based on medical, psychological, and social needs that is supervised by a Physician.
- G. Meets licensing standards.

OUTPATIENT BEHAVIORAL CARE FACILITY

The term “Outpatient Behavioral Care Facility” means an administratively distinct governmental, public, private, or independent unit, or a part of such unit, that provides Outpatient Behavioral Care services, and that provides for a psychiatrist who has regularly scheduled hours in the facility and assumes the overall responsibility for coordinating the care of all patients.

PARTICIPANT

The term “Participant” means an Employee or former Employee who meets the eligibility requirements and who is properly enrolled in the Plan.

PARTICIPANT COVERAGE

The term “Participant Coverage” means coverage included under this Plan providing benefits payable as a consequence of an Injury or Illness of a Participant or, if allowable under the Plan, for Routine preventive care for a Participant.

PHI

See Protected Health Information.

PHYSICAL THERAPY

The term “Physical Therapy” means the treatment of disorders with physical agents and methods under the supervision of a licensed physical therapist, including, but not limited to, massage, manipulation, therapeutic exercises, cold, heat (including shortwave, microwave, and ultrasonic diathermy), hydrotherapy, electric stimulation, and light to assist in rehabilitating individuals and in restoring normal function after an Illness or Injury. Also called physiotherapy.

PHYSICIAN

The term “Physician” means a legally licensed medical or dental doctor or surgeon, chiropractor, osteopath, podiatrist, optometrist, perfusionist, certified consulting Psychologist, or limited licensed psychologist to the extent that he/she, within the scope of his/her license, is permitted to perform services provided in this Plan. The term Physician may include a Physician’s Assistant or Nurse Practitioner, but shall not include the Covered Person or any Close Relative of the Covered Person.

PHYSICIAN’S ASSISTANT

The term “Physician’s Assistant” means one who has been trained in an accredited program and is certified by an appropriate board to perform certain of a Physician’s duties, who is acting within the scope of his or her license, and who is under the supervision of a licensed Physician.

Services provided by a Physician’s Assistant will be considered to be Covered Expenses under the Plan, based on all Plan provisions, limitations, and requirements.

PLAN

The term “Plan” means the Health Benefit Plan for Detroit Academy of Arts & Sciences, as periodically amended.

PLAN ADMINISTRATOR

The term “Plan Administrator” means **DETROIT ACADEMY OF ARTS & SCIENCES**, who is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services.

PLAN SPONSOR

The term “Plan Sponsor” means **DETROIT ACADEMY OF ARTS & SCIENCES**.

PLAN YEAR

For purposes of Form 5500 reporting (if required), and compliance with the Patient Protection and Affordable Care Act (PPACA), as amended, the term “Plan Year” means the 12-month period that begins on October 1 and ends on the following September 30.

For all other purposes including Deductibles, out-of-pocket limits, other annual benefit-based accumulators, and compliance with other laws issued subsequent to PPACA, the term “Plan Year” means the 12-month period that begins on January 1 and ends on the following December 31.

PREGNANCY

The term “Pregnancy” means the physical state that results in childbirth, abortion, or miscarriage and any medical complications arising out of or resulting from that state.

PROTECTED HEALTH INFORMATION

The term “Protected Health Information” means information that is created or received by the Plan or a Business Associate and relates to the past, present, or future physical or mental health or condition of a Covered Person, the provision of health care to a Covered Person, or the past, present, or future payment for the provision of health care to a Covered Person. Also, the information identifies the Covered Person or there is a reasonable basis to believe the information can be used to identify the Covered Person (whether living or deceased). The following components of a Covered Person’s information will enable identification:

- Names
- Street address, city, county, precinct, ZIP code
- Dates directly related to a Covered Person’s receipt of health care treatment, including birth date, health facility admission and discharge date, and date of death
- Telephone numbers, fax numbers, and electronic mail addresses
- Social security numbers
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers and serial numbers, including license plate numbers
- Device identifiers and serial numbers
- Web Universal Resource Locators (URLs)
- Biometric identifiers, including finger and voice prints
- Full face photographic images and any comparable images
- Any other unique identifying number, characteristic, or code

PSYCHOLOGIST

The term “Psychologist” means an individual holding the degree of Ph.D., Psy.D., or Ed.D. and acting within the scope of his or her applicable licenses.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The term “Qualified Medical Child Support Order (QMCSO)” means an order pursuant to OBRA 1993 and applicable state law that requires the Plan to provide health coverage to a participating Employee’s child. A QMCSO may either be obtained under state domestic

relations law or may be initiated by a court or state administrative agency pursuant to applicable state law. The Plan Administrator shall develop procedures to determine whether an order submitted to the Plan constitutes a QMCSO pursuant to OBRA 1993 and applicable state law.

REGISTERED NURSE

The term “Registered Nurse” means an individual who has received specialized nursing training, is authorized to use the designation of “R.N.,” and is duly licensed by the state or regulatory agency responsible for licensing in the state in which the individual performs nursing services.

ROOM AND BOARD

The term “Room and Board” refers to all charges, by whatever name called, that are made by a Hospital, Hospice, or Convalescent Nursing Facility as a condition of occupancy. Charges do not include the professional service of Physicians or intensive nursing care by whatever name called.

ROUTINE

The term “Routine” means services provided to individuals for the purpose of promoting health and preventing illness or injury, including evaluation and management of individuals when these services are performed in the absence of patient complaints.

SEMI-PRIVATE

The term “Semi-Private” refers to a class of accommodations in a Hospital or Convalescent Nursing Facility in which at least two patients’ beds are available per room.

SPECIAL ENROLLMENT PERIOD

The term “Special Enrollment Period” means the period for an individual with special enrollment rights to make enrollment elections under the Plan. The circumstances under which an individual has special enrollment rights are described in the Participant Enrollment and Dependent Enrollment sections and are prescribed by HIPAA and federal regulations issued pursuant to HIPAA.

SPEECH THERAPY

The term “Speech Therapy” means the treatment of disorders of articulation, language, and voice under the supervision of a licensed speech therapist, including, but not limited to, evaluation of motor-speech skills; expressive and receptive language skills; writing and reading skills; cognitive functioning; social interaction skills; and the development of speech, listening, and conversation skills.

SUMMARY HEALTH INFORMATION

The term “Summary Health Information” means information that may be individually identifiable health information. It summarizes the claims history, claims expenses, or types of claims experienced by individuals for whom Plan Sponsor has provided health benefits under the

Plan. The information described in 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information may be aggregated to the level of five-digit ZIP codes.

TOTAL DISABILITY; TOTALLY DISABLED

The term “Total Disability” or “Totally Disabled” means a physical state of a Covered Person resulting from an Illness or Injury that wholly prevents either of the following activities:

- A. A Participant engaging in any and every business or occupation and performing any and all work for compensation or profit.
- B. A Dependent performing the normal functions and activities of a person of like age and gender in good health.

USUAL AND CUSTOMARY

The term “Usual and Customary” refers to the designation of a charge as being the usual charge made by a Physician or other provider of services, and supplies, medications, or equipment that do not exceed the general level of charges made by other providers rendering or furnishing such care or treatment within the same area. The term “area” in this definition means a county or other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances that require additional time, skill, or expertise.

UTILIZATION REVIEW FIRM

The term “Utilization Review Firm” means the entity providing mandatory Hospital admission certification and other utilization review services in connection with the Plan.

NO RIGHTS UNDER ERISA

The Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA, does not apply to this Plan. The fact that the Plan may, in some respects, conform to the requirements of ERISA, or include provisions often found in plans that are subject to ERISA, shall not be interpreted or construed to mean that the Plan is intended to comply with ERISA, or that Employees, Participants, or beneficiaries have any rights under ERISA. The preceding statement also pertains to other federal laws that do not apply to the Plan.

RULES OF CONSTRUCTION

This Plan shall be construed in accordance with the Code, and, where not pre-empted, the laws of the state of Michigan.

The use of the singular includes the plural where applicable and vice versa. The headings do not limit or extend the provisions of the Plan. Capitalized terms, except where capitalized solely for grammar, have the meaning provided in the Plan. Errors cannot cause the Plan to provide a benefit that a Covered Person is not otherwise entitled to under the Plan. If a provision is unenforceable in a legal proceeding, the provision shall be severed solely for purposes of that proceeding and the remaining provisions of the Plan shall remain in full force.

Detroit Academy of Arts & Sciences has caused this amended and restated Plan to be effective as of 12:01 a.m. local time, October 1, 2016.

DETROIT ACADEMY OF ARTS & SCIENCES

By _____
Authorized Representative

Witness

Date

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