TORRANCE UNIFIED SCHOOL DISTRICT
MEDICAL AND DRUG PLANS

SUMMARY PLAN DESCRIPTION

MEDICAL AND DRUG PLANS

Effective Date: October 1, 2020

Contract Administrator:

PINNACLE CLAIMS MANAGEMENT, INC.
P.O. Box 2200
Newport Beach, CA 92658
PH: (800) 649-9121

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INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Participants, in accordance with the terms and conditions described herein. Plan benefits are self-funded through a benefit fund established by the Plan Sponsor and funded solely from the general assets of the Plan Sponsor.

The Plan operates under a detailed legal plan document. If this summary plan description (SPD) is incomplete in some respect or can be read to be inconsistent with the legal plan document, the plan document will control.

The purpose of this Summary Plan Description ("SPD") is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for medical care and directly related prescription charges. The Plan Document is maintained by the Plan Administrator and may be inspected at any time during normal working hours by any Covered Person.

General Plan Information

Name of Plan:	Torrance Unified School District Medical and Drug Plans
Plan Sponsor/Plan Administrator	Torrance Unified School District
Address:	2335 Plaza Del Amo Torrance, CA 90501
Business Phone Number	(310) 972-6036
Participating Employer(s):	Torrance Unified School District
Plan Sponsor ID No. (EIN):	95-6003151
Source of Funding:	Self-Funded
Plan Status:	Non-Grandfathered
Plan Year:	October 1st through the last day of September
Plan Type:	This is an employee welfare benefit plan providing group benefits. The plan administrator contracts with a third-party service provider to administer the Plan.
Plan Benefits described herein:	Self-Funded Health Benefits
Named Fiduciary:	Plan Administrator Torrance Unified School District
Address:	2335 Plaza Del Amo Torrance, CA 90501
Designated Legal Agent: (Legal process may be served upon the Plan Sponsor or a Fiduciary)	Plan Administrator Torrance Unified School District
Address:	2335 Plaza Del Amo Torrance, CA 90501
Contract Administrator:	Pinnacle Claims Management, Inc.

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

Not a Contract

This SPD and any amendments constitute the terms and provisions of coverage under this Plan. The SPD shall not be deemed to constitute a contract of any type between the Employer and any Covered Person or to be consideration for, or an inducement or condition of, the employment of any Covered Person. Nothing in this SPD shall be deemed to give any Covered Person the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Covered Person at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Employer with the bargaining representatives of any Covered Person.

Applicable Law

As an IRC S403(b) plan, this plan is not subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Any use of language that implies or is similar to that required under ERISA is solely for administration purposes and is not intended to subject this plan to ERISA.

Conformity with Law

If any provision of this Plan is contrary to any law to which it is subject, **such provision is hereby amended to conform to such law.**

Adjustments for Prior Plan Administrator Coverage

This document is a restatement of prior coverage(s) offered by the Plan Administrator and is intended to replace the prior coverage(s). Except to the extent that benefits are expressly modified, it is not intended that benefits will be reduced or increased for an Eligible Participant who was covered under the prior coverage(s) on the day of discontinuance and who is eligible as an active enrollee or a COBRA enrollee under the Summary Plan Description on its effective date. Any deductibles satisfied or benefits paid with respect to such covered persons under the prior coverage(s) will be deemed to be Deductibles satisfied or benefits paid under the Summary Plan Description. Any contiguous periods an Eligible Participant was covered under a prior coverage(s) of the Plan Administrator will be deemed to be time covered under the Summary Plan Description

Discretionary Authority

The Plan Sponsor shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Covered Persons' rights; and to determine all questions of fact and law arising under the Plan. The Plan Sponsor has the discretion and authority to amend the benefit plan at any time, subject to the terms of any applicable collective bargaining agreement.

All decisions and determinations of the Plan Sponsor with respect to any matter hereunder shall be conclusive and binding on Covered Persons and all other interested parties, except where expressly prohibited by applicable laws or regulations.

Funding - Sources And Uses

Source Of Plan Contributions

The benefits described herein are funded by contributions of the Plan Sponsor and, when applicable, the Plan Participant and eligible Dependent. The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code and such other applicable laws and regulations.

The Plan Sponsor shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Employee, when applicable, (handled through a Section 125 pre-tax premium ("contribution") plan). The Plan Administrator is free to determine the manner and means of funding this Plan, to the extent permitted by governing law.

Funding medium through which benefits are provided

Benefits described herein are self-funded by the Plan Sponsor. COBRA beneficiaries must pay for the coverage individually without any contributions from the Plan Administrator and are generally 102% of the full cost of coverage for active (Non-COBRA) enrollees, except in special circumstances where a greater cost is allowed by law.

Taxes

Any premium or other taxes which may be imposed by any state or other taxing authority and which are applicable to the coverages of the Plan will be paid by the Plan Sponsor.

To provide benefits, purchase insurance protection, pay administrative expenses and any other necessary taxes, the contributions which are paid by Employees will be used first and any remaining Plan obligations will be paid by Employer contributions. Should total Plan liabilities in a Plan Year be less than the total Employee contributions any excess will be applied to reduce total Employee contribution requirements in the subsequent Plan Year or, at Plan Sponsor's discretion, may be used in any other manner which is consistent under applicable law. Benefits described in this book are not insured and there is no liability on the part of Torrance Unified School District Benefit Plan or any individual or entity to provide these benefits in excess of the available assets of the Plan. Pinnacle Claims Management, Inc. is a contractual not a fiduciary administrator.

Plan Administration

Fiduciaries

Fiduciaries will serve at the discretion of the Plan Administrator and may serve without compensation, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. The Plan Administrator may at any time and from time to time remove any Fiduciary or appoint new Fiduciaries. Any Fiduciary may resign at any time upon 30 days' notice in writing delivered to the Plan Administrator. Fiduciaries may act at a meeting or without a meeting, by a majority of the Fiduciaries at the time in office. The Fiduciaries may appoint an individual as its secretary who will have such powers and responsibilities relating to the administration of benefits under the Plan as the Fiduciaries may delegate.

Fiduciary Responsibility, Authority and Discretion

Fiduciaries will discharge their duties under the Plan solely in the interest of the Plan Participants and their beneficiaries and for the exclusive purpose of providing benefits to Employees and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Administrator.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and SPD, even if the terms are found to be ambiguous, and to determine eligibility for and entitlement to plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

The Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to third party administrators or provider networks) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant, or other person or third party selected by them, any power or duty vested in, imposed upon or granted to them by the Plan. However, the Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: 1) establishing or implementing the Plan procedures for allocation or delegation, 2) allocating or delegating the responsibility, or 3) continuing the allocation or delegation.

Plan Administrator

The Plan Administrator has the authority and responsibility to:

1. Call and attend the meetings at which the funding policy and method of the Plan are established and reviewed;
2. Establish the Plan policies, interpretations, practices and procedures and rendering final decisions on review of claims as described in this SPD;
3. Comply with all reporting and disclosure statements under applicable federal and state law;
4. Hire and contract all persons providing services to the Plan;
5. Receive all disclosures required of fiduciaries and other service providers under applicable federal or state law;
6. Act as the Plan's agent for the service of legal process;
7. Act as this Plan's Privacy Officer for purposes of HIPAA; and,
8. Perform all other responsibilities allocated to the Plan Administrator in the instrument appointing the Plan Administrator.

The Plan Administrator will have the duty, power, and discretion to construe and interpret the Plan, to decide all questions or eligibility and to determine the amount, manner, and time of payment of any benefits under the Plan, except where limited by law. All determinations will be made on a non-discriminatory basis and consistently applied to similarly situated individuals. All interpretations under the Plan, and all determinations of fact made in good faith by the Plan Administrator, will be final and binding on the Participants and beneficiaries and all other interested parties.

Contract Administrator

The Contract Administrator shall have the authority and responsibility for:

1. Interpreting the Plan's provisions relating to coverage except where the Contract Administrator requests an interpretation or a claimant files an appeal with the Plan Administrator, in which case the Plan Administrator shall interpret the Plan and shall communicate in writing to the Contract Administrator the appropriate interpretation of the Plan;
2. Administering the Plan's claim procedures;
3. Processing checks for benefits in accordance with Plan provisions;
4. Filing claims with the insurance companies, if any, who issue stop loss insurance policies to the Employer;
5. Transmitting and certifying such information as needed by the Plan Administrator to file the annual report under Internal Revenue Code Section 6039D; and
6. Performing all other responsibilities delegated to the Contract Administrator in the instrument appointing the Contract Administrator.

Action By Employer / Plan Sponsor

Any authority or responsibility allocated or reserved to the Employer under the Plan may be exercised by any duly authorized officer of the Employer.

Advisors To Fiduciaries

A named fiduciary or his delegate may retain the services of actuaries, attorneys, accountants, brokers, employee benefit consultants, and other specialists to render advice concerning any responsibility such fiduciary has under the Plan.

Multiple Fiduciary Functions

Any named fiduciary may serve in more than one (1) fiduciary capacity with respect to the Plan.

Co-Fiduciary Liability

A fiduciary shall not have liability for a breach of fiduciary duty of another fiduciary, unless he participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach and fails to take action to remedy such breach, or, through his negligence in performing his own specific fiduciary responsibilities, enables such other fiduciary to commit a breach of the latter's fiduciary duty.

Notice of Appointments or Delegations

A named fiduciary shall not recognize or take notice of the appointment of another named fiduciary, or the delegation of responsibilities or a named fiduciary, unless and until the Employer notifies the named fiduciary in writing of such appointment or delegation. The named fiduciaries may assume that an appointment or delegation continues in effect until the named fiduciary receives written notice to the contrary from the Employer.

Type of Plan

The Plan(s) is/are a self-funded group health plan(s). Plan benefits are not guaranteed under a contract or policy of insurance.

IMPORTANT NOTICES

Who To Contact For Additional Information

A Covered Person can obtain additional information from the office that handles claims on behalf of the Plan (the "Contract Administrator"). See the first page of the **General Plan Information** section for the name, address and phone number of the Contract Administrator.

Definitions

Some of the terms used in this document begin with a capital letter. These terms have special meanings and are included in the **Definitions** section and throughout this SPD. When reading this document, it will be helpful to refer to this section. Becoming familiar with the terms defined therein will provide a better understanding of the benefits and provisions.

COBRA Notice Requirements

In some circumstances, an Employee or a Qualified Beneficiary is the first to know that a COBRA Qualifying Event has occurred (e.g., in the case of a divorce or legal separation, or where a Child reaches a maximum age limit and is no longer eligible). In such instances, it is the Employee or the COBRA Qualified Beneficiary's responsibility to provide notice to the Plan that a COBRA Qualifying Event has occurred.

The procedures for providing notice of a COBRA Qualifying Event are included in the Employer's COBRA notice communication piece that is provided to newly-hired Employees. The procedures are also included herein and are located immediately following the **COBRA Continuation Coverage section** (see the **COBRA Notice Procedures for Covered Persons** section). Please review that section for additional details or contact the Plan Sponsor for the most current notice procedures.

NOTE: It is important that the Plan Sponsor be kept informed of the current addresses of all Plan Participants or beneficiaries who are or may become COBRA Qualified Beneficiaries.

The Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean delivery. However, Federal law generally does not prohibit the mother's or newborn's attending provider (see NOTE), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTE: An "attending provider" does not include a plan, hospital, managed care organization or other issuer.

The Women's Health And Cancer Rights Act

Under Federal law, group health plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending physician and the patient: (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce symmetrical appearance, (3) breast prostheses, and (4) physical complications of all stages of mastectomy, including lymphedemas.

Childrens' Health Insurance Program (CHIP)

Effective April 1, 2009, Employees and Dependents who are eligible but not enrolled for the Employer's group health plan, may enroll for coverage thereunder in the following instances:

- Loss of Medicaid or CHIP Eligibility: If the Employee or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, the

Employee may request coverage under the Employer's group health plan coverage within sixty (60) days after Medicaid or CHIP coverage terminates.

- Eligibility for State Premium Assistance: Where a State has chosen to offer premium assistance subsidies for qualified Employer-sponsored benefits (see NOTES) and if the Employee or Dependent becomes eligible for such subsidy under Medicaid or CHIP, then the Employee may request coverage under the Employer's group health plan within sixty (60) days after eligibility for the subsidy is determined.

Also, if an Employee's child(ren) become eligible for CHIP, he or she has the ability to drop the child(ren) from the group health coverage.

NOTES: Children's' Health Insurance Program Reconciliation Act allows states to elect to offer premium assistance subsidies to qualified individuals. Such subsidies are not mandated.

Mental Health Parity & Addiction Equity Act

Under Federal law, group health plans that already provide coverage for mental health conditions and/or substance addictions (referred to in the law as "substance use disorders") must provide coverage for such covered conditions in the same manner as coverage is provided for Sickness. This law applies to group health plans on their Plan Year anniversary beginning on or after October 3, 2009.

NOTE: The Plan is not required to provide coverage for mental health conditions or substance use disorders. Also, the Plan (and not the Act) determines what will be a covered mental health condition and/or a covered substance use disorder. This legislation does not apply to employers with fewer than 51 employees.

Genetic Information And Non-Discrimination Act

GINA (Genetic Information and Non-discrimination Act) applies to a group health plan on its Plan Year beginning after May 21, 2009. The Act makes it illegal for group health plans to deny coverage or charge a higher rate or premium to an otherwise healthy individual found to have a potential genetic condition or genetic predisposition towards a disease or disorder. The Plan's eligibility and coverage provisions exclude denial of benefits or increased rates due to a potential or predisposition of a genetic condition of covered Employees and their families.

The Act defines genetic information as that obtained from an individual's genetic test results, as well as genetic test results of family members and the occurrence of a disease or disorder in family members.

HIPAA Privacy

The Plan Sponsor has a policy not to retaliate or discriminate against, or intimidate any Covered Person who exercises his/her privacy rights. The company also has a policy not to require anyone to waive his/her privacy rights as a condition of treatment, payment, enrollment in a health plan, or eligibility for benefits.

CASE MANAGEMENT AND UTILIZATION MANAGEMENT PROGRAM

The Case Management and Utilization Review Program is designed to help ensure that all eligible Plan Participants receive necessary and appropriate health care while avoiding unnecessary expenses by requiring certification.

Utilization Management
Pinnacle Claims Management, Inc.
(800) 274-7767

Pre-Service Review Requirements

The Plan Sponsor has contracted with an independent organization to provide pre-service review. The name and phone number of the organization is shown on the Employee's coverage identification card.

Compliance Procedures

The procedures outlined below should be followed to avoid a possible penalty:

Hospital Admission - Except as noted, prior to any Hospital admission that is not due to an Emergency Medical Condition, the Covered Person or someone acting on his behalf must contact the Utilization Management Organization for pre-service review and authorization at least three (3) business days prior to admission. For an emergency admission, the Utilization Management Organization must be contacted within forty-eight (48) hours after admission.

Inpatient services requiring inpatient pre-certification include, but are not limited to:

- Acute care
- Long term acute care
- Skilled Nursing Facility
- Rehabilitation
- Detoxification
- Mental health and substance abuse hospitalization and partial hospitalization
- Mental health and substance abuse residential
- Surgeries performed on an inpatient basis

If, in the opinion of the patient's Physician, it is necessary for the patient to be confined for a longer time than initially authorized, the Physician may request that additional days be authorized by contacting the Utilization Management Organization no later than the last authorized day.

Penalty for Non-Compliance - If the above pre-service review requirements (i.e., the "Compliance Procedures") are not followed and completed or if the admission, procedure, service or supply is not authorized, then **benefits will be reduced by 50%**.

NOTE: Pre-service review will not be required for the following:

- an Inpatient admission for Pregnancy delivery that does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. However, if/when the Pregnancy confinement for the mother or newborn is expected to exceed these limits, pre-service review for such extended confinement is required.
- An inpatient admission for a mastectomy and lymph node dissection.

Specified Treatment, Services & Supplies – Prior to receiving any of the following treatment, services and supplies, the Covered Person or someone acting on his behalf must contact the Utilization Management Organization for pre-service review and authorization:

- Ambulatory Surgery Center

Penalty for Non-Compliance - If the above pre-service review requirements (i.e., the "Compliance Procedures") are not followed and completed or if the admission, procedure, service or supply is not authorized, then **benefits will be reduced by 50%**.

- Organ and Tissue Transplants

***No benefits if admission, procedure, service or supply is not authorized.**

Case Management

The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "CASE MANAGEMENT AND/OR UTILIZATION REVIEW", shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other eligible Plan Participant, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case management occurs when this alternative benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once an agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

NOTE: Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate in case management.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Alternative Care

In addition to the benefits specified in this document, the Plan Administrator may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for an eligible Plan Participant whose condition would otherwise require Inpatient care.

The Plan shall provide such alternative benefits for so long as it is determined that alternative services are Medically Necessary and cost effective, and that the total benefits paid for such services do not exceed the total benefits to which the patient would otherwise be entitled under the Plan in the absence of alternative benefits.

If the Plan Administrator elects to provide alternative benefits for an eligible Plan Participant in one instance, it shall not be obligated to provide the same or similar benefits for that person or other eligible Plan Participants in any other instance, nor shall it be construed as a waiver of the Plan Sponsor's right to administer the Plan thereafter in strict accordance with its express terms.

In-Network Providers

No Choice Of Providers

The Plan Sponsor has contracted with an organization or " In-Network" of health care providers. **WARNING**: THIS PLAN PROVIDES COVERAGE ONLY WHEN CERTAIN PROVIDERS ARE USED. PLEASE READ THE FOLLOWING INFORMATION TO KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTHCARE MAY BE OBTAINED. A LIST OF COVERED PROVIDERS WILL BE PROVIDED TO COVERED PERSONS WITHOUT CHARGE.

In order to receive the benefits of the Plan - except in certain limited situations, which are identified below or within this Plan Document – ALL NON-EMERGENCY HEALTHCARE must be provided or authorized by Providers participating in the networks identified below. A list of Participating Providers is available to Covered Participants without charge.

In-Network – Anthem Blue Cross
www.anthem.com/ca

Blue Cross Blue Shield of Arizona: www.azblue.com
CCN/First Health: www.ccnusa.com

In-Network providers have agreed to provide services to Covered Persons at negotiated rates. When a Covered Person uses an In-Network provider his out-of-pocket costs may be reduced because he will not be billed for expenses in excess of those rates. The Plan may also include other benefit incentives to encourage Covered Persons to use In-Network providers whenever possible - see the Schedule of Medical Benefits, below.

In the following limited circumstances, Out-of-Network provider expenses will be covered at the In-Network benefit levels. The In-Network benefit levels will be applied to Out-of-Network Usual, Customary and Reasonable charges:

Emergency Services: If a Covered Person requires care for an Emergency Medical Condition and must use the services of an Out-of-Network provider, any such expenses will be paid at In-Network benefit levels until the patient's condition has been stabilized to the point that he could be transferred to In-Network provider care. At that point, the Covered Person must be transferred to In-Network-provider care.

Unavailable Services - If a Covered Person uses an Out-of-Network provider specialist because, after thorough evaluation and approval by the Plan, the necessary specialty is not represented in the Network or is not reasonably accessible to the patient due to geographic constraints, such Out-of-Network specialist care will be covered at the In-Network benefit levels.

MEDICAL BENEFIT SCHEDULE

Determination of Covered Expenses and Medical Necessity

Subject to the exclusions, conditions and limitations stated in this SPD, the Plan will pay benefits to, or on behalf of, a Claimant for covered Medical Expenses up to the maximums specified within the SPD. The Plan will pay benefits for the Negotiated Fee or Medicare fee schedules for services and supplies, which are ordered by a Physician. Covered Expense is limited to those charges that are necessary to prevent, diagnose or treat disease, defect or injury. Services and supplies must be furnished by an eligible Provider and be Medically Necessary. All payments made under the Plan for allowable charges will be limited to Medicare fee schedules and allowances and/or Negotiated Fee Rate.

The fact that a procedure or level of care is prescribed by a Physician does not mean that it is Covered Expense under the Plan and shall not bind the Plan. in determining the liability under the Plan. Services which are not reasonable and necessary shall include, but are not limited to:

1. procedures that are experimental, of unproven value or of questionable current usefulness;
2. procedures that tend to be redundant when performed in combination with other procedures;
3. procedures that are unlikely to provide a Physician with additional information when they are used repeatedly;
4. procedures that can be performed with equal efficiency at a lower level of care.
5. Errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in safety and creditability of a health care facility; also known as “Never Events” as adopted by the Centers for Medicare and Medicaid Services (“CMS”).
6. Reasonably preventable condition(s) that are not present or identifiable at the time of Hospital admission, but was present at the time of discharge; also known as “Hospital Acquired Condition(s)” as adopted by the CMS.
7. services, procedures, drugs, or treatments that have been previously performed or provided to the patient for the same diagnosis and have not effectively treated or cured the patient when performed or provided in the past; unless approved through Case Management.

Approval of a claim is subject to the determination of the Medical Necessity of provided services. Medical Necessity is a broadly accepted professional term meaning services were essential to treatment of the Illness or Injury. Treatment determined to be Medically Necessary will follow guidelines where such treatment:

- is consistent with symptoms or diagnosis and treatment of the condition, disease, ailment or Injury;
- is deemed appropriate, essential and is recommended for the diagnosis or treatment of the patient’s symptoms by a licensed Provider who is practicing within the scope of his or her license and specialty, or primary area of practice;
- is within to scope, duration and intensity of that level of care that is required to provide safe, adequate and appropriate diagnosis or treatment;
- is prescribed in accordance with the generally accepted, current professional medical practice and is not considered Experimental or Investigational;
- is appropriate with regard to standards of good medical practice;
- is not primarily for the conveniences of the patient, the Physician or other Provider;
- is the most appropriate supply or level of services that can safely be provided to the patient. When applied to an inpatient, it means the patient’s medical symptoms or condition require services or supplies which cannot be safely provided to the patient as an outpatient.

In determining Medical Necessity, the Plan may choose to utilize any of the following:

- Utilization Review Center/Utilization Management
- Case Management Organization

- Medicare
- Standard Accepted Medical Practice
- Other Third Party Experts and Professionals

All Medical Necessary determinations will be made on a non-discriminatory basis and will be consistently applied to all Claimants with the same medical symptoms, diagnosis, and history.

Please refer to the **Definitions** section of this SPD for a complete definition of Medical Necessity or Medically Necessary.

The obligation of the Plan shall be fully satisfied by the payment of allowable expenses in accordance with this SPD. Benefits will be paid for the reimbursement of Medical Expense incurred by the Claimant if all provisions mentioned in this SPD are satisfied.

The fact that a Physician may prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary or make the charge an allowable expense, even though it is not specifically listed as an exclusion.

Schedule of Medical Benefits

The percentages shown in the schedule reflect the amounts payable of Eligible Expenses after any required Deductible or Copayment has been subtracted. A “Deductible” is the amount of Eligible Expenses that a Covered Person must pay each year before benefits are payable. A “Copayment” is an amount the Covered Person must pay separately and usually in lieu of a Deductible and is paid to the provider at the time of service.

See “Usual, Customary and Reasonable” in the **Definitions** section for more information.

Physicians and other Providers who have contracted with the medical provider Network are called “In-Network Providers.” Those who have not contracted with the Networks are referred to in this Plan as “Out-of-Network Providers.”

Out-of-Network Providers are health care providers who do not have a contract with Anthem to discount their fees. **Services provided by Non-Network Providers are not covered under the Plan,** with the exception of emergency and certain radiology and anesthesiology services.

Benefits available to In-Network Providers are limited such that if an In-Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will ONLY be paid in accordance with the terms of the Plan.

MEDICAL BENEFIT SUMMARY

This is an Exclusive Provider Option (EPO) plan, and **coverage is only provided when services are obtained by Participating Providers**. The exception to this provision is for an Emergency or for referrals by a Participating Provider to a Non-Participating Provider for laboratory, x-rays or diagnostic services. See each service as defined herein for benefits resulting from a referral.

All Plan benefits are subject to all of the provisions, exclusions & limitations explained in detail throughout this Plan Document. The following represents only a summary of the available benefits. Please refer to the other sections within this Plan Document for additional information on your Plan benefits.

A. General Features

Lifetime Maximum Benefit	Unlimited
Participating Provider Network	**California**: Anthem Blue Cross Prudent Buyer Plan Network **Arizona**: Blue Cross Blue Shield of Arizona **Outside California and Arizona**: First Health
Maternity Coverage	Participant, Spouse, or Dependent Child
Plan Year Deductible: Individual and Family	None
Out-of-Pocket Maximum: Individual Family	 $2,000 $4,000
Except as noted, a Covered Person will not be required to pay more than **$2,000 as an Individual or $4,000 as a Family** in any Plan Year toward his share of Eligible Expenses which are not paid by the Plan. Once a Covered Person has met their out-of-pocket maximum, Eligible Expenses will be paid at 100% of the Negotiated Fee or Usual and Customary rates for the remainder of the Plan Year. The following will not be applied to the Out-of-Pocket Maximum: (i) Non-Covered Expense; (ii) Penalties for failure to pre-certify; (iii) Amounts paid at 100%; (iv) Infertility services not billed by a Hospital.	

B. Paid Hospital Expenses

Note: Services must be received from a Participating Provider.

	You Pay	**Plan Pays**
Inpatient Care (Includes Room & Board, Ancillary Charges, Intensive Care) ***Pre-Certification required, subject to 50% reduction in payable benefits***	$250 Copay + 10% of Covered Expense	90% of Remaining Covered Expenses
Ambulatory Surgery Center ***Pre-Certification required, subject to 50% reduction in payable benefits***	10% of Covered Expense	90% of Covered Expense
Outpatient Surgery in Hospital Setting	10% of Covered Expense	90% of Covered Expense
All Other Outpatient Hospital Services	10% of Covered Expense	90% of Covered Expense
Preadmission Testing	10% of Covered Expense	90% of Covered Expense

C. Covered Expenses

Note: With the exception of treatment for Emergency Medical Conditions, only services received from Participating Providers are covered under the Plan.

	You Pay	Plan Pays
Acupuncture Services ***Limited to 26 visits per Plan Year combined with Chiropractic Care***	$30 Copay per visit	100% of Remaining Covered Expense
Allergy Injections / Treatment	$25 Copay per visit	100% of Remaining Covered Expense
Ambulance	10% of Covered Expense	90% of Covered Expense
Chiropractic Care ***Limited to 26 visits per Plan Year combined with Acupuncture Services***	$30 Copay per visit (Copay waived for Chiropractic X-rays)	100% of Remaining Covered Expense
Diagnostic X-Ray & Lab	$0	100% of Covered Expense
Durable Medical Equipment	10% of Covered Expense	90% of Covered Expense
Emergency Room		
Outpatient due to Sudden & Serious Illness	$150 Copay	100% of Remaining Covered Expense
With Hospital Admission or within 48 hours of an accident	$250 Copay + 10% of Covered Expense	90% of Remaining Covered Expense
Emergency Room Physician Services	$25 Copay	100% of Remaining Covered Expense
Home Health Care ***Limited to 100 visits per Plan Year***	10% of Covered Expense	90% of Covered Expense
Hospice Care		
Patient Care	10% of Covered Expense	90% of Covered Expense
Bereavement Counseling ***Limited to 8 visits for members of immediate family during the 6 months following death***	$25 Copay per visit	100% of Remaining Covered Expense
Mental Health and Substance Use Treatment		
Inpatient Care ***Precertification required, subject to 50% reduction of benefits payable***	10% of Covered Expense	90% of Covered Expense
Outpatient Care	$25 Copay per visit	100% of Remaining Covered Expense
Occupational Therapy ***Limited to services to restore physical function***	$30 Copay per visit	100% of Remaining Covered Expense
Physical Therapy ***Precertification required after 26 visits.***	$30 Copay per visit	100% of Remaining Covered Expense

	You Pay	Plan Pays
Physician Services		
Office/Home Visit ***Maximum of 1 Copay per day if multiple services are billed in conjunction with the office visit.***	$25 Copay per visit	100% of Remaining Covered Expense
Hospital visit – Inpatient	10% of Covered Expense	90% of Covered Expense
Pregnancy & Maternity Care ***Precertification required, subject to 50% reduction of benefits payable***		
Office visit – initial visit and any diagnostic visits outside the Global Fee for delivery	$25 Copay per visit	100% of Remaining Covered Expense
All other visits associated with the Global Fee for delivery	$0	100% of Covered Expense
Normal Delivery, cesarean section and complications of pregnancy prior to birth or to the mother	10% of Covered Expense	90% of Covered Expense
Inpatient Physician Services and Hospital Services	10% of Covered Expense	90% of Covered Expense
Preventive Care ***Federally-mandated Preventive care services, as described in Appendix A.***	$0	100% of Covered Expense
Skilled Nursing Services ***Precertification required, subject to 50% reduction in benefits.*** ***Limit: 100 days per Plan Year.***	10% of Covered Expense	90% of Covered Expense
Speech Therapy	$25 Copay per visit	100% of Remaining Covered Expense
Urgent Care Facility	$25 Copay per visit	100% of Remaining Covered Expense

D. Utilization Management

Inpatient Admissions	Requires review at least 3 working days before admission for non-Emergency Hospital admissions, and within 48 hours of admission for Emergency Hospital admissions. Failure to pre-certify will result in 50% benefit reduction. Non-compliance penalties will not apply to the Out-of-Pocket Maximum.
Outpatient Surgery at Surgery Center Maternity Care	Pre-certification required, subject to 50% benefit reduction.

E. Prescription Drug Benefits

Type of Medication	**Retail 30-Day Supply**	**Retail 90-Day Supply**	**Mail Order**
Generic – Tier I	$10	$30	$20 (90-Day Supply)
Preferred Brand – Tier II	$30	$90	$60 (90-Day Supply)
Non-Preferred Brand – Tier III	$50	$150	$100 (90-Day Supply)
Specialty Medications	Tier I - $10 Tier II - $30 Tier III - $50	Not Available	30-Day Supply Only Tier I - $10 Tier II - $30 Tier III - $50

ELIGIBLE MEDICAL EXPENSES

This section is a description of those medical expenses for services and supplies that are covered by the Plan. This section must be read in conjunction with the **Medical Benefit Summary** to understand how Plan benefits are determined.

Eligible medical expenses are the Negotiated Rate for the items listed below and that are incurred by an eligible Covered Person - subject to the **Definitions, General Exclusions** and all other provisions of the Plan. In general, services and supplies must be approved by and received from a Physician or other appropriate Covered Provider and **must be Medically Necessary** for the care and treatment of a covered Sickness, Accidental Injury or Federally-required preventive care.

For benefit purposes, expenses will be deemed to be incurred on:

- the date a purchase is contracted; or
- the actual date a service is rendered.

NOTE: Benefits are only payable for In-Network Providers.

Acupuncture: Needle puncture or application of pressure at specific points, used to relieve pain, when rendered by a licensed Physician or licensed Acupuncturist.

Allergy Testing & Treatment: Allergy testing and treatment, including allergy injections.

Ambulance (including Air Ambulance): Licensed professional Ambulance service for Medically Necessary transportation to or from the nearest Hospital where appropriate care can be obtained is payable at the Plan's Percentage Payable for Participating Providers. Prior authorization of non-emergency transportation is required, regardless of Physician's orders. Approval of the transportation must be obtained by the Plan or benefits may be reduced or denied. Determination of a Medical Emergency is at the sole discretion of the Plan.

Use of an Ambulance is subject to retrospective Utilization Review to determine if the type of transportation services were Medically Necessary. Distance from a facility is not in and of itself a Medically Necessary reason for use of ambulance services.

Ambulatory Surgical Center: Services and supplies provided by an Ambulatory Surgical Center (see Definitions) within the Plan's network in connection with a covered Outpatient surgery.

Anesthesia: Anesthetics and services of a Physician and/or certified registered nurse anesthetist (CRNA) for the administration of anesthesia.

Attention Deficit Disorders (ADD & ADHD) are a Covered Expense for testing and treatment of ADD or ADHD. Regular Plan benefits will be paid for these services and treatment.

Behavioral Health Treatment Services: Services are limited to the treatment of pervasive developmental disorder or autism and are limited to professional services and treatment programs including Applied Behavior Analysis and evidence-based behavior intervention programs that develop or restore, to the extent practicable, the functioning of the Covered Person.

Birthing Center/Midwife: A Birthing Center must be operated by a Physician or registered nurse/midwife, is designed for normal deliveries and postpartum newborn care, and is in compliance with licensing and other legal requirements in the jurisdiction where it is located. It is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients and maintains daily clinical records.

Blood: Blood Transfusions, Blood, and Blood Plasma are a Covered Expense if ordered by a Physician for the treatment of a sickness or injury, when not available to the Participant without charge.

Cardiac Rehabilitation: A monitored exercise program directed at restoring both physiological and psychological well-being to an individual with heart disease. The program must be:

- under the supervision of a Physician;
- in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery;
- initiated within twelve (12) weeks after treatment for the medical condition ends;
- provided in a covered medical care facility as defined by the Plan; and
- limited to 36 visits.

NOTE: Maintenance care is not covered.

Chemotherapy & Radiation Therapy: Outpatient services and supplies related to the administration of chemical agents in the treatment or control of a Sickness.

Radium and radioactive isotope therapy when provided for treatment or control of a Sickness.

Chiropractic Care: Musculoskeletal manipulation and modalities (e.g., hot & cold packs) provided by a chiropractor (DC) to correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain.

Routine services include initial exam, initial x-ray and manipulation of the spine. This benefit does not include MRI's, CT scans, PT scans, nutritional supplements/vitamins, or Durable Medical Equipment or Supplies.

Contraceptive Drugs and Devices: are Covered Expenses when prescribed by a Physician and include: oral contraceptive drugs, intrauterine contraceptive devices (IUD's), intradermal contraceptive devices (e.g. Norplant), Depo-Provera injections, and insertion and/or removal of intradermal contraceptive devices. Contraceptive devices and medications do not apply to the Out-of-Pocket Maximum.

NOTE: Oral contraceptives are only covered under the "Outpatient Prescription Drug Program."

Cosmetic Surgery after Mastectomy: In a manner determined in consultation with the attending Physician and the patient are payable for:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery or reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications with all stages of the mastectomy, including lymphedemas.

Benefits are payable as any other surgical claim and are based on location of services.

Dermatology: Services rendered for medically necessary dermatology services provided by a licensed Dermatologist.

Diagnostic Lab, X-ray & Imaging, Outpatient: Laboratory, X-ray and other non-surgical services performed to diagnose medical disorders, electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the United States.

Diabetic Daycare Self-Management Education Programs and related Nutritional Counseling. Covered Expense includes the charges of a diabetic day care center and for the services of a Physician or other professionals who are knowledgeable about the treatment of diabetics (such as a registered nurse, registered pharmacist, registered dietician or nutritionist) for the purposes of enabling diabetics and their families to understand and practice daily management of diabetes. Coverage will also include visual aids (but not eyeglasses) to assist with proper dosing of insulin and other Medically Necessary equipment and supplies.

Dialysis: Dialysis services and supplies, including the training of a person to assist the patient with home dialysis, when provided by a Hospital, freestanding dialysis center or other appropriate Covered Provider.

Durable Medical Equipment: Rental of durable medical equipment (but not to exceed the fair market purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost-effective due to a long-term need for the equipment. Such equipment must be prescribed by a Physician and received from a Network Provider.

Repair of purchased equipment when necessary to maintain its usability. Replacement of equipment but only if it is: (1) less than five (5) years old, (2) needed due to a change in the patient's physical condition, or (3) likely to cost less to buy a replacement than to repair existing equipment or rent like equipment.

"Durable medical equipment" includes items such as crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen and dialysis equipment that: (1) can withstand repeated use, (2) are primarily and customarily used to serve a medical purpose, (3) generally are not useful to a person in the absence of Sickness or Accidental Injury, and (4) are appropriate for use in the home.

NOTES: Coverage is limited to the least expensive item that is adequate for the patient's needs. Duplicate equipment and excess charges for deluxe equipment or devices are not covered.

Breast pumps are covered at no cost sharing to the Covered Person as required by the Affordable Care Act. See Appendix for **Federally Required Preventive Care**.

No benefits are payable for durable medical equipment prescribed or provided for or in connection with chiropractic treatment.

Foot Care: Treatment of mycotic toenails and removal of nail matrix or root. The treatment of routine foot care and removal of corns, calluses, toenails, or subcutaneous tissue when care is prescribed by a Physician treating metabolic or peripheral vascular disease, is also a Covered Expense.

No benefits are available for the following:

a) Orthotic inserts and devices

b) Treatment of bunions when open cutting operation or arthroscopy is performed

c) Palliative/Routine hygienic foot care

d) Trimming of nails, corns or calluses when there is not a metabolic disease

Genetic Counseling and Testing: Eligible Expenses include genetic testing that is Medically Necessary for genetic counseling and BRCA testing, if appropriate, as a preventive service without cost-sharing. See Appendix for **Federally Required Preventive Care Services**.

Genetic testing is not a Covered Expense for population screening without a personal or family history, with the exception of newborn screening and preconception or prenatal carrier screening for certain conditions, such as cystic fibrosis, Tay-Sachs disease, sickle cell disease and other hemoglobinopathies; informational purposes; minors for adult-onset conditions and a relative of a plan participant who is not an eligible Dependent.

Home Health Care: Services and supplies that are furnished in accordance with a written home health care plan. The home health care plan must be established by the attending Physician and must be monitored by the Physician during the period of home health care. Also, the attending Physician must certify that the condition would require Inpatient confinement in a Hospital or Skilled Nursing Facility in the absence of home health care.

Home health care services and/or supplies must be provided through a Home Health Care Agency or by other Covered Providers as specified in the written home health care plan. Covered home health care services and supplies include, but are not limited to, the following:

a) part-time or intermittent services of a registered nurse (RN) or a licensed practical nurse (LPN);

b) services of physical, occupational and speech therapists;

c) part-time or intermittent services of home health aides under the supervision of a registered nurse (RN) or a physical, occupational or speech therapist; and

d) medical supplies, drugs and medicines prescribed by a Physician and laboratory services, but only to the extent that such items would have been covered if the patient had been confined in a Hospital or Skilled Nursing Facility.

NOTE: Covered home health care expenses will not include: (1) food, food supplements, home-delivered meals, transportation, housekeeping services or other services that are custodial in nature and could be rendered by non-professionals, (2) services provided by an individual who ordinarily dwells in the household or is related to eligible Plan Participant by blood or marriage, or (3) services rendered while receiving Hospice Home Services.

Hospice Care: Care of an eligible Plan Participant or eligible Dependent with a terminal prognosis for up to two 90-day periods followed by unlimited 60-day periods of care, depending on the diagnosis, who has been admitted to a formal program of Hospice care. Covered Expenses include Hospice program charges for:

a) Inpatient Hospice facility services and supplies;

b) professional and other services and supplies including, but not limited to: (1) nursing care by a registered nurse, a licensed practical nurse, a vocational nurse or a public health nurse who is under the direct supervision of a registered nurse, (2) physical therapy and speech therapy when rendered by licensed therapists, (3) medical supplies, including drugs and biologicals and the use of medical appliances, (4) Physician services, and (5) services, supplies and treatments deemed Medically Necessary and ordered by a Physician;

c) Bereavement counseling; and,

d) Continuous Skilled Nursing Care except as specifically provided as a part of Respite Care.

NOTE: The following will not be covered with respect to Hospice Care Services:

a) Hospice Services and supplies not ordered, provided and billed through a Hospice;

b) Hospice Services provided during any period of time in which an eligible Plan Participant is receiving private duty Skilled Nursing Care that is a Covered Medical Service;

c) pastoral or spiritual counseling;

d) services performed by family members or volunteer workers;

e) homemaker or housekeeping services, except by Home Health Aides as ordered in the Hospice Treatment Plan;

f) supportive environmental materials including but not limited to handrails, ramps, air conditioners and telephones;

g) normal necessities of living including but not limited to food, clothing and household supplies;

h) food services such as “Meals on Wheels”;

i) separate charges for reports, records or transportation; and

j) services and supplies not included in the Hospice treatment plan or not specifically set forth as a Hospice Care Services.

Hospital Services: Hospital services and supplies provided on an Outpatient basis and Inpatient care, including daily room and board and ancillary services and supplies, when provided by a participating Hospital.

Inpatient Care: The Plan will reimburse Covered Expenses for semi-private room and board and necessary Ancillary Expenses including special diet, the services of a dietician and general nursing services when an eligible Plan Participant is an Inpatient in a Hospital. Covered expenses will include Cardiac Care Units, nursery units, and Intensive Care Units; when appropriate for the eligible Plan Participant’s Illness or Injury. After twenty-three (23) observation hours, a confinement will be considered an Inpatient confinement.

The following services and supplies are covered when provided by a Hospital:

a) Use of operating, delivery and treatment rooms and equipment;

b) Prescribed drugs administered while the eligible Plan Participant is an Inpatient;

c) Administration and processing of whole blood and blood products when use in a transfusion of an eligible Plan Participant and are not donated on behalf of an eligible Plan Participant or replaced through contribution by or on behalf of an eligible Plan Participant;

d) Anesthesia, anesthesia supplies and services rendered by the Hospital as a regular Hospital service and billed by the Hospital in conjunction with a procedure that is a Covered Medical Service;

e) All medical and surgical dressings, supplies, casts and splints that have been ordered by a Physician, furnished by a Hospital and are not specifically constructed braces and supports;

f) Oxygen and administration of oxygen; and

g) Diagnostic Services and Therapy Services. If Diagnostic Services and Therapy Services furnished through a Hospital are provided in part or in full by a Physician under contract with the Hospital to perform the services, and the Physician bills separately for them, the Physician's services shall be a Covered Medical Expense.

Outpatient Services: Treatment, services and supplies furnished by a participating Hospital on an Outpatient basis to an eligible Plan Participant not admitted as a registered bed patient. The following services and supplies are covered while not an Inpatient:

a) Emergency room services and supplies, including the services and supplies of a Hospital for the treatment of Accidental Injuries, Diseases, Illnesses and Mental Illness or Substance Abuse, Emergency Room visits will have a broader definition for those states which allow denial of coverage based on diagnosis;

b) Outpatient care provided by a Hospital for the treatment of Mental Illness and/or Substance Abuse must be a treatment under a program that meets the standards established by the Office of Drug and Alcohol Abuse Programs or the Mental Health Division (or the equivalent agency if the Services are provided outside or California); and

c) Services for Surgery and supplies provided by a Hospital or Ambulatory Surgical Facility including the removal of sutures, anesthesia, services and supplies rendered by an Employee of the Hospital or Ambulatory Surgery Facility who is not the Surgeon or assistant at Surgery, in conjunction with a procedure that is a Covered Medical Service.

Infertility Treatment: Procedures, drugs or supplies to diagnose or correct infertility or to restore or enhance fertility.

NOTE: Benefits are limited to a lifetime maximum of $10,000. The following are not Covered Expenses: (i) In-vitro fertilization; (ii) storage of embryo or cord blood.

Infusion Therapy: Professional services of an appropriate Covered Provider for the intravenous or aerosol administration of prescription drugs or other prepared or compounded substances. Infusion therapy may be administered in an eligible Plan Participant's home, Physician's office or at a Covered Provider facility.

Infusion therapy supplies including injectable prescription drugs or other substances that are approved by the Food and Drug Administration, and durable medical equipment necessary for infusion therapy.

Injectables: Injectables are medicines that are dispensed using a hypodermic syringe and/or needle for Medically Necessary conditions ordered by a Physician in a medical clinic, Physician's office, or by a Physician for the patient to self-inject. For Injectables dispensed in the Physician's office that are in the following categories, benefits are payable as any other Physician office visit:

- Antibiotics, Pain Medications, and Medically Necessary steroids;
- Non-routine immunizations (not for Well Child Care or Preventive Care); or
- Immunotherapy agents (allergy injections)

Self-Injectables are Covered Expense only when dispensed through specialty Rx vendor see **Prescription Drugs Benefit**).

Maternity/Pregnancy Care: Benefits are payable in the same manner as for medical or surgical care of an Illness, and subject to the same maximums. These services include normal Pregnancy, complication of Pregnancy, and elective abortion, provided the services are rendered by a Hospital or a Physician.

Normal Pregnancy includes all conditions arising from Pregnancy or delivery including any condition usually associated with the management of a difficult Pregnancy. Services of a certified or registered nurse midwife when provided in conjunction with a covered Pregnancy.

Pregnancy-related expenses for pre-natal and post-partum care are covered.

Please note that surrogate pregnancy is not a covered benefit.

Involuntary complications of Pregnancy include but are not limited to Cesarean section delivery, ectopic Pregnancy that is terminated, spontaneous termination of Pregnancy, puerperal infection and eclampsia. Involuntary complications of Pregnancy also include conditions requiring Inpatient confinement, the diagnoses of which are distinct from Pregnancy such as acute nephritis, cardiac decompensation, and similar medical and surgical conditions of comparable severity. In addition, conditions requiring Inpatient confinement may include false labor, occasional spotting, Physician-prescribed bed-rest, morning Illness, hyperemesis, gravidarum or preeclampsia.

Expenses incurred and services rendered that are Covered Medical Services under normal Pregnancy or involuntary complication of Pregnancy will be treated as Covered Medical Services when incurred or rendered in connection with an abortion for an eligible Plan Participant, regardless of the reason if the eligible Plan Participant is otherwise eligible for Maternity Services.

NOTE: Benefits for elective abortion do not apply to the Out-of-Pocket Maximum.

Under the Newborns' and Mothers' Health Protection Act of 1996, group Plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for a mother or Newborn Child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or Newborn's attending Provider, after consulting with the mother, from discharging the mother or her Newborn earlier that forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers ay not, under federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

NOTE: Does not include adoption expenses or surrogacy expenses.

Medical Emergency: An accidental Injury or the sudden onset of a medical condition of sufficient severity that the absence of immediate medical attention could reasonably be expected to:

- Put you or, with respect to a pregnancy, Your unborn child, in serious jeopardy;
- Result in serious impairment of bodily functions; or
- Result in serious dysfunction of any bodily organ or part.

Medical Emergencies include, but are not limited to, suspected heart attack, loss of consciousness, actual or suspected poisoning, acute appendicitis, heat exhaustion, convulsions, emergency medical care rendered in accident cases and other acute conditions.

For purposes of benefits payable under this Plan, the Claims Administrator will determine the existence of Medical Emergency. A Medical Non-Emergency is care which can safely and adequately be provided by other than in a Hospital.

Sudden & Serious Illness

A Sudden & Serious Illness is any condition that begins suddenly and is considered out of the ordinary. A Sudden & Serious Illness usually includes:

- Temperature above 102° (oral) or 103° (rectal)
- Chest pain with sudden onset

- Profuse Hemorrhage
- Severe abdominal pain of sudden onset
- Acute respiratory distress
- Obvious severe mental distress
- Life-threatening situations
- Visits to the Emergency room requiring Emergency Hospital admission

Life-Threatening Condition

A Life-Threatening Condition is defined as a sudden and unexpected onset of a medical condition requiring medical or surgical care. Life-Threatening Conditions usually include:

- Severe chest pain
- Profuse hemorrhaging (bleeding)
- Difficulty in breathing
- Sudden onset of weakness or paralysis of a body part
- Unconsciousness
- Convulsions
- Severe burns
- Multiple injuries or trauma
- Partial or complete severing of a limb
- Ingestion of a poisonous substance

Medicines: Medicines that are dispensed, administered to a Covered Person during a Physician's office visit. See the **Prescription Benefit** section for pharmacy drugs.

Medical Supplies, Disposable: Disposable medical supplies such as surgical dressings, catheters, colostomy bags and related supplies.

Mental Health Care / Substance Use Disorder Care: Services and supplies for the treatment of covered mental health conditions and covered substance use disorders. Treatment of mental health conditions and substance use disorders may be provided through inpatient or outpatient services, emergency care and prescription drugs. Services or supplies provided in a specialized facility not meeting medical guidelines and criteria herein defined are not a Covered Expense.

Mental Health Conditions: For Plan purposes, a "mental health condition" is any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of *International Classification of Diseases*, published by the U.S. Department of Health and Human Services or is listed in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association.

Learning and behavioral disorders are eligible medical expenses and payable based on the type of treatment.

NOTE: A mental health condition or covered mental health care will not include:

- Intellectual disability;
- hypnotherapy;
- marriage and family counseling;
- sex counseling or sex therapy; or
- vocational testing or training.

NOTE: The above exclusions may be covered to a limited degree if required by law.

Substance Use Disorders: Covered "substance use disorders" include physical and/or psychological dependence on drugs, narcotics, alcohol, toxic inhalants, or other addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine.

Multiple Surgical Procedures: Subject to the following provisions:

a) if bilateral or multiple surgical procedures are performed by one (1) Surgeon, benefits will be determined based on the on the Usual and Customary Charge that is allowed for the primary procedure; 50% of the Usual and Customary charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

b) if multiple unrelated surgical procedures are performed by two (2) or more Surgeons on separate operative fields, benefits will be based on the Usual and Customary charge for each Surgeon's primary procedure. If two (2) or more Surgeons perform a procedure that is normally performed by one (1) Surgeon, benefits for all surgeons will not exceed the Usual and Customary percentage allowed for that procedure; and

c) if an assistant Surgeon is required, the assistant Surgeon's Covered Charge will not exceed 25% of the Surgeon's Usual and Customary allowance.

Newborn Care: Medically Necessary eligible medical expenses for a covered newborn who is sick or injured for the first 30 days or as required by the Newborns' and Mothers' Health Protection Act – see below.

In accordance with the Newborns' and Mothers' Health Protection Act, the Plan will provide a covered well newborn with up to forty-eight (48) hours of benefits following a normal vaginal delivery or up to ninety-six (96) hours following a cesarean section delivery. The "Prior Authorization" requirements for inpatient Hospital admissions will not apply for this minimum length of stay. Early discharge is only permitted if the decision is made between the attending Physician and the mother. See NOTE, below.

NOTE: A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an eligible Dependent.

Nursing Services (Including Nurse Practitioners): Medically Necessary nursing services that are not provided for housekeeping, personal hygiene or custodial care.

NOTE: Does not include private duty nursing.

Occupational Therapy: Professional services of an in-network licensed occupational therapist, when rendered under the direction of a Physician. Limited to 26 visits, then subject to medical necessity.

Orthotics: Orthopedic (non-dental) braces, casts, splints, trusses and other orthotics that are prescribed by a Physician and that are required for support of a body part due to a congenital condition, or an Accidental Injury or Sickness. Replacement of an orthotic is not covered except for replacement that is Medically Necessary due to a change in the eligible Plan Participant's physical condition.

NOTE: No benefits are payable for orthotics prescribed or provided for or in connection with chiropractic treatment. Orthotic inserts are not covered. See "Foot Care, Routine" in the list of **Medical Limitations and Exclusions**.

Outpatient Diagnostic Imaging. Outpatient Diagnostic Imaging is covered if ordered by a Physician, licensed technician, or clinic for the diagnosis of an illness or injury being treated and is paid at the Participating Provider Plan Percentage Payable of Covered Expense. Outpatient Diagnostic Imaging includes Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET) scans, Bone Density testing, Computed Tomography (CT) scans, and any cardiac diagnostic procedure utilizing nuclear medicine.

Physical Therapy: The treatment by physical means ordered by a Physician and includes aquatic therapy, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysical principles, or devices to relieve pain, restore maximum function or prevent disability following a condition, Disease, Illness,

Accidental Injury or loss of a body part. Physical therapy must be ordered by a Physician and rendered by a licensed technician or clinic. Pre-authorization is recommended for extended treatments. Services limited to 26 visits, then subject to Medical Necessity.

Physician Services: Medical diagnosis, consultation, anesthetic and surgical treatment by a participating Physician (MD or DO).

- **Surgical Services** are a Covered Expense for Medically Necessary services performed by a healthcare Provider licensed and acting within the scope of his or her license and payable at the Plan's Percentage Payable of Covered Expense.
- **Dental Surgery** for the treatment of tumors of the gums, a fractured jaw, or an Injury to sound natural teeth when such conditions require pathological exams sustained while covered under this Plan; excision of partially or completely impacted teeth; reduction of fractures and dislocations of the jaw; external incision and drainage of cellulitus; incision of accessory sinuses, salivary glands or ducts; excision of exostosis of jaws and hard palate; frenectomy; gingival mucosal surgery to treat gingivitis or periodontitis; apicoectomy; root canal therapy if performed in conjunction with an apicoectomy; and alveolectomy (not payable if performed in conjunction with routine extraction of natural teeth).
- **Mastectomies** are a Covered Expense for the following services: repair or correction from illness or injury sustained in an Accident that occurred while the person was eligible under the Plan; reconstructive surgery following a mastectomy, including surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy;
- **Reconstructive surgery** that is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to improve function or create a normal appearance is Covered Expense. Orthodontic services deemed Medically Necessary for cleft palate, cleft lip or related craniofacial anomalies shall also be covered if prior authorization is received.
- **Multiple Surgical Procedures** performed by one (1) or more Physicians during the same operative session will be considered Covered Expense according to the following:
    - The lesser of the actual charges or the negotiated fee will be allowed for the primary surgical procedure.
    - Fifty percent of the lesser of the actual charges or the negotiated fee o for the secondary surgical procedure.
    - Twenty-five percent of the lesser of the actual charges or the negotiated fee for the third and all other procedures billed.
- **Bilateral Surgical Procedures** performed by one (1) or more Physicians during the same operative session will be considered Covered Expense according to the following:
    - The lesser of the actual charges or the negotiated fee for the primary surgical procedure.
    - Fifty percent of the lesser of the actual charges or the negotiated fee for the secondary or bilateral surgical procedure.
- **Multiple Traumatic Injuries** performed by one (1) or more Physicians during the same operative session will be considered Covered Expense according to the following:
    - The lesser of the actual charges or the negotiated fee will be allowed for each procedure performed on a separate bodily area or system.
    - The lesser of the actual charges or the negotiated fee will be allowed for the primary procedure performed on the same bodily area or system.
    - Fifty percent of the lesser of the actual charges or the negotiated fee for the secondary surgical procedure.
- **Co-Surgeons** for Medically Necessary and approved surgical procedures requiring two (2) or more Physicians for the same operative procedure, where each Physician is the primary surgeon, will be considered Covered Expense according to the following:
    - The lesser of the actual charges or the negotiated fee will be allowed for each Physician.

Services received in a network facility from a non-network provider are paid at the network rate.

Preventive Care: Federally-required preventive services that are provided in the absence of Sickness or Injury. In general, services and supplies must be approved by and received from a Physician or other appropriate Covered In-Network Provider and must be at a frequency recommended by the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics, based on your age and risk factors for federally-required preventive care.

NOTE: USPSTF stands for the United States Preventive Services Task Force. Approved USPSTF preventive services have a rating of A or B. Frequency is also limited to "Reasonable or Reasonableness" as defined in **Definitions**.

See the **Appendix** for further information.

Professional Interpretation Services (Inpatient and Outpatient): Covered Medical Services include interpretation and reporting by a licensed Radiologist or Pathologist for covered Diagnostic tests. Benefits are provided only for testing required for the diagnosis or treatment of an Illness or Injury, unless otherwise provided under Preventive Care.

Prosthetics: External prosthetics such as artificial limbs, eyes or other appliances to replace natural body parts, including the fitting and adjustment of such appliances.

Internally implanted prosthetics such as pacemakers and hip and knee joint replacements.

Post-mastectomy breast prostheses as required by the Women's Health and Cancer Rights Act.

NOTE: Prosthetics coverage does not include:

a) artificial organs;

b) dental prosthetics, except as expressly included under "Dental Care" in the **Medical Limitations and Exclusions** section;

c) speech aids or voice replacement devices except when required following surgical removal of the larynx; or

d) repair or replacement of a prosthetic device except for replacement that is Medically Necessary due to a change in the eligible patient's physical condition.

Prescription Drugs: Medicines that are prescribed to a Covered Person during a Physician's office visit are covered as described in the **Prescription Benefit Summary**.

Routine Patient Costs for Participation in an Approved Clinical Trial: Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Covered Person is participating in a phase I, II, III or IV Approved Clinical Trial, conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition, provided:

1. The clinical trial is approved by:

   a. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;

   b. The National Institute of Health;

   c. The U.S. Food and Drug Administration;

   d. The U.S. Department of Defense;

   e. The U.S. Department of Veterans Affairs; or

   f. An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and

2. The research institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the institution, agree to accept reimbursement at the applicable Covered Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Coverage will **not** be provided for:

1. The cost of an investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial;
2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial;
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4. A cost associated with managing an Approved Clinical Trial;
5. The cost of a health care service that is specifically excluded by the Plan; or
6. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research institution conducting the Approve Clinical Trial.

Second Surgical Opinions: Covered expenses include a second opinion to determine the Medical Necessity for a recommended surgical procedure. Benefits are paid as any other specialist visit consultation.

Skilled Nursing Facility or Rehabilitation Center: Inpatient care in Skilled Nursing Facility or Rehabilitation Center, but only when the admission to the facility or center is Medically Necessary and is:

a) preceded by confinement in a Hospital and is for the same condition causing the preceding Hospital confinement;

b) ordered by a Physician in lieu of Hospital confinement;

c) part of a written treatment plan prepared by the Physician specifying the diagnosis, course of treatment, and

d) projected with a discharge date.

Sleep Disorders: Includes services, supplies, medications, and testing related to the diagnosis and treatment of sleep disorders, such as insomnia, narcolepsy, sleep apnea, and parasomnia. Excludes modifications to prescribed durable equipment.

“Sleep disorders” include insomnia, narcolepsy, sleep apnea and parasomnias.

NOTE: These benefits do not apply to the Out-of-Pocket Maximum.

Speech Therapy: Speech-language pathology services for the treatment of disorders of speech, language, voice, communications and auditory processing are covered when the disorder results from injury, stroke, cancer, congenital or developmental anomalies, or autism-spectrum disorders.

- Services of a Speech Pathologist or other licensed healthcare professional, within the scope of his or her licensure may be covered when:
  - There is a need for the supervision of a licensed therapist for Speech-language therapy, swallowing or feeding rehabilitative services or restorative therapy services.
  - The services are part of a treatment plan with documented goals for functional improvement of the patient’s condition.
  - The teaching of patient or caregiver is required to strengthen muscles, improve feeding techniques or improve speech-language skills to progress toward the documented treatment goals. Once the patient or caregiver are trained, the services are no longer skilled, and are considered custodial by the Plan and will no longer be covered.

- Mandated benefits by federal and state laws for Speech Therapy. Examples may include Developmental Delay, autism, cleft palate and/or lip, aphasia.

- Treatment of congenital anomaly which includes, but is not limited to, down syndrome and cleft palate.
- Treatment of injury affecting speech:
  - Speech loss related to otitis media is covered.
  - Vocal cord injuries (e.g., edema, nodules, polyps)
  - Stroke/CVA
  - Trauma
  - Cerebral palsy
  - Static encephalopathy
- Rehabilitation services for feeding and/or swallowing, restorative therapy services:
  - Swallowing disorders (Dysphagia)
  - Feeding disorders including problems with gathering food and sucking, chewing, or swallowing food.
  - Auditory rehabilitation which includes Speech-language Therapy (e.g., when an auditory implant or cochlear implant is covered under the Plan)

  Outpatient rehabilitation can occur in the following settings:

  - Physician's office
  - Therapist's office
  - Covered Person's place of residence
  - Separate part of a clinic or hospital where speech therapy is performed.
- Treatment of developmental delays affecting speech.

Sterilization Procedures: A surgical procedure for the purpose of sterilization (i.e., a vasectomy for a male or a tubal ligation for a female).

Reversal of a Sterilization Procedure is **not** covered.

Temporomandibular Joint Dysfunction (TMJ): Jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex muscles, nerves and other tissues related to the temporomandibular joint are covered.

Tobacco Addiction: See the **Appendix** for Federally-required Preventive Benefits.

Transplant-Related Expenses: Covered Expenses for kidney, kidney/pancreas, pancreas, liver, heart, lung, heart/lung, small bowel, and bone marrow or stem cell transplants for certain conditions, including all Medically Necessary post-surgical treatment and drugs, subject to the following conditions:

- Covered transplant must be pre-authorized by the Utilization and Care Manager to be payable and Plan Participant must participate in case management.
- The transplant recipient is a Plan Participant.
- Benefits for the donor are reduced by any amounts paid or payable by the donor's own coverage, if applicable. If donor benefits are not a covered benefit under the donor's health plan, no claims will be reimbursed or considered a covered expense under this Plan.
- Includes travel expenses for a living donor.

Covered expenses for travel, housing and unrelated transplant searches are payable as indicated in the **Schedule of Benefits**.

Urgent Care Facility: Covered Expenses that are incurred by an eligible Plan Participant at an in-network Urgent Care Facility that is separate from a Hospital.

Vaccinations: The following immunizations or vaccinations:

- Immunizations and vaccinations covered as a preventive care service, as shown in the Appendix), and
- Tetanus or rabies vaccinations administered in connection with an Accidental Injury.

Vitamins or Dietary Supplements: Prescription or non-prescription organic substances used for nutritional purposes, including Megavitamin therapy under Federally-required Preventive Benefits. See Appendix.

MEDICAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated otherwise, no benefits will be payable for:

Air Purification Units, Etc.: Air conditioners, air-purification units, humidifiers and electric heating units.

Alternative Therapy: Care and treatment related to aversion therapy, hypnosis therapy, primal therapy, Rolfing, psychodrama or megavitamin therapy.

Biofeedback: Biofeedback, recreational, or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing.

Chiropractic Appliances: Appliances which include, but not limited to braces for the leg, wrist or foot. These appliances are also excluded from Durable Medical Equipment.

Cosmetic & Reconstructive Surgery, Etc.: Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic that is within the broad range of normal but that may be considered unpleasing or unsightly, except for:

- services necessitated by an Accidental Injury;
- reconstructive surgery to correct damage to a body part resulting from disease or infection;
- coverage required by the Women's Health and Cancer Rights Act (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including lymphedemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient; and
- treatment necessary to correct a congenital abnormality (birth defect) resulting in the malformation or absence of a body part.

Custodial & Maintenance Care: Care or confinement primarily for the purpose of meeting personal needs which could be rendered at home or by persons without professional skills or training.

Any type of maintenance care which is not reasonably expected to improve the patient's condition, except as may be included as part of a formal Hospice care program.

Dental & Oral Care: No charge will be covered under Medical Benefits for routine dental or oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

Ecological or Environmental Medicine: Chelation or chelation therapy, orthomolecular substances, or use of substances of animal, vegetable, chemical or mineral origin that are not specifically approved by the FDA as effective for treatment.

Environmental change, including Hospital or Physician expenses incurred in connection with prescribing an environmental change.

Educational or Vocational Testing or Training: Testing and/or training for educational purposes or to assist an individual in pursuing a trade or occupation.

Training of an eligible Plan Participant for the development of skills needed to cope with an Accidental Injury or Sickness, except as may be expressly included.

Exercise Equipment / Health Clubs: Exercising equipment, vibratory equipment, swimming or therapy pools. Enrollment in health, athletic or similar clubs.

Experimental / Investigational Treatment: See **General Exclusions**.

Eye Care: Radial keratotomy or other eye Surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. Reversals or revisions of these surgical procedures and complication of those surgical procedures are excluded, except when required to correct an immediately life-endangering condition.

Foot Care, Routine: Routine and non-surgical foot care services and supplies including, but not limited to:

- Orthotic inserts;
- Treatment of bunions when open cutting operation or arthroscopy is performed;
- Palliative/routine hygienic foot care; and,
- Trimming of toe nails, corns or callouses when there is not a metabolic disease.

NOTE: This exclusion does not apply to Medically Necessary treatment of the feet (e.g., the removal of nail roots, other podiatry surgeries, or foot care services necessary due to a metabolic or peripheral-vascular disease).

Growth Hormone Therapy: The use of growth hormone (GH) as a prescription medication.

Habilitation Services: Habilitative services such as respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training.

Hair Restoration: Any surgeries, treatments, drugs, services or supplies relating to baldness or hair loss, whether or not prescribed by a Physician; except if primary diagnosis is cancer.

Hearing Aids and Related Exams: Charges for services or supplies in connection with external hearing aids or exams for their fitting. Charges for services or supplies in connection with implantable hearing devices (e.g., cochlear, soundtec).

Homeopathic: Services, supplies, drugs or accommodations provided in connection with homeopathic.

Hypnotherapy: Treatment by hypnotism.

Impotence; Sexual Dysfunction: Care, treatment, services, supplies and medication for impotence and sexual dysfunction; including, but not limited to, penile implants, sexual devices or any medications or Drugs pertaining to sexual dysfunction or impotence, except when Medically Necessary.

Infertility: The following services are excluded:

- Artificial insemination, in-vitro fertilization, G.I.F.T. (Gamete Intrafallopian Transfer) or any type of artificial impregnation procedure, whether or not any such procedure is successful.
- Storage of embryo or cord blood.

Inpatient Admissions: That are the following:

- primarily for Diagnostic Services or Therapy Services; or
- when the eligible Plan Participant is Ambulatory or confined primarily to bed rest, special diet, behavioral problems, environmental change or for treatment not requiring continuous bed care.

Intellectual Disability: Treatment of or any services relating to intellectual disability unless Medically Necessary.

Learning Disorders: Testing or treatment for learning disorders is limited to speech therapy, occupational therapy or other Medically Necessary rehabilitative services.

Maintenance Care: See “Custodial & Maintenance Care.”

Non-Prescription Drugs: Drugs for use outside of a hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician’s written prescription - except as may be included in the Plan’s prescription coverages.

Drugs for which there is a non-prescription equivalent available.

Not Generally Accepted: Any services or supplies that are not in accordance with generally accepted professional medical standards.

Not Medically Necessary: Any services or supplies that are not Medically Necessary.

Not Physician Prescribed: Any services or supplies that are not recommended on the advice of a Physician, unless expressly included herein.

Inpatient room and board when hospitalization is for services that could have been performed safely on an Outpatient basis including, but not limited to: preliminary diagnostic tests, physical therapy, medical observation, treatment of chronic pain or convalescent or rest cure.

Personal Comfort or Convenience Items: Services or supplies that are primarily and customarily used for nonmedical purposes or are used for environmental control or enhancement (whether or not prescribed by a Physician) including but not limited to: (1) air conditioners, air purifiers, or vacuum cleaners, (2) motorized transportation equipment, escalators, elevators, ramps, (3) waterbeds or non-hospital adjustable beds, (4) hypoallergenic mattresses, pillows, blankets or mattress covers, (5) cervical pillows, (6) swimming pools, spas, whirlpools, exercise equipment, or gravity lumbar reduction chairs, (7) home blood pressure kits, (8) personal computers and related equipment, televisions, telephones, or other similar items or equipment, (9) food liquidizers, or (10) structural changes to homes or autos.

Private Duty Nursing: Charges in connection with care, treatment or services of a private duty nurse.

Replacement Braces: Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the eligible Plan Participant's physical condition to make the original device no longer functional.

Reversals or Revisions: Charges for surgical procedures and complications of those surgical procedures are excluded except when required to correct an immediately life-endangering condition.

Routine Exams - School/Sports/License: Routine exams, physicals or anything not ordered by a Physician or not Medically Necessary for treatment of Sickness, Accidental Injury, Pregnancy, or for an examination required through or on account of employment; for a marriage license, or for insurance, school, or camp application; or screening examination.

Self-Procured Services: Services rendered to an eligible Plan Participant who is not under the regular care of a Physician and for services, supplies or treatment, including any periods of hospital confinement, that are not recommended, approved and certified as necessary and reasonable by a Physician, except as may be specifically included in the list of **Eligible Medical Expenses**.

Sterilization Reversal: A sterilization reversal of a prior sterilization procedure.

Surrogate Pregnancy: Coverage for a contracted pregnancy (any pregnancy entered into for a third party) is excluded from this Plan. Any complications due to such a pregnancy will not be covered by the Plan.

Vaccinations: Immunizations or vaccinations, unless expressly included as a Covered Expense in **Eligible Medical Expenses**.

Vocational Testing or Training: Vocational testing, evaluation, counseling or training.

Weekend Admissions: Hospital expenses incurred on a weekend which coincides with admission to a Hospital between 12:00 (noon) on Friday and 12:00 (noon) on Sunday unless: (1) the admission occurs one day prior to a scheduled surgery, (2) the eligible Plan Participant is admitted on an emergency basis, or (3) the admission is for Pregnancy delivery.

Weight Control: Services and supplies for treatment of obesity.

Wigs, Toupees, Hairpieces, etc.: Except in relation to cancer treatment or for other Medically Necessary conditions, including, but not limited to, alopecia areata.

*- (See also **General Exclusions** section) -*

PRESCRIPTION MEDICATION BENEFIT SUMMARY

Prescription drug coverage is provided through separate agreement(s) between the Plan Sponsor and a prescription program vendor.

Pharmacy Vendor: PinnacleRx Solutions (PRxS)
www.prxsolutions.com
Toll-Free Telephone Number: 877.782.9658

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A prescription for a medicine or drug must be a written or electronic order that satisfies the legal requirements for a prescription in the state of purchase.

Retail Pharmacy Medications

Medications are covered at the specified copayments. If the medication is a maintenance medication and the medication is either a Generic or Formulary Brand Name Medication, the Covered Person may also obtain the medication from the mail order program (see next section).

Mail Order Maintenance Medications

If the Covered Person is on a maintenance medication, he or she may use the mail order program. Maintenance Medication means any medication prescribed for long-term treatment of chronic conditions and used to stabilize an illness or symptoms of an illness. By using the mail order program, the Covered Person will be able to receive a 90-day supply. When appropriate, PinnacleRx Solutions uses generic medications to fill prescriptions.

Schedule Of Prescription Benefits

Type of Medication	30-Day Retail Option Copays	90 Day Mail Service Option Copays	90 Day Retail Option Copays
Generic – Tier I	$10	$20	$30
Preferred Brand – Tier II	$30*	$60*	$90*
Non-preferred Brand – Tier III	$50*	$100*	$150*
***Brand-name drugs are not covered if a generic equivalent is available and it is not Medically Necessary to use the brand-name drug rather than the generic.** There is no charge for contraceptives that are generic or single-source brand.			

Covered Drugs

Covered drugs include most prescription drugs (i.e., federal legend drugs and compounded drugs which are prescribed by a Physician and which require a prescription either by federal or state law) and certain non-prescription items.

You must receive Your outpatient Prescription Drugs through a Participating Pinnacle Rx Solutions Pharmacy, which is a national network of Participating Pharmacies. For all covered medications, You are responsible to pay the prescription Copayment based upon the type of drug dispensed for a Participating pharmacy, or the mail order program, and the Plan will pay the remainder of the Covered Expense.

Copayments apply to each new and refill prescription drug. Copayments are not reimbursable. Outpatient prescription drugs are limited to a quantity not to exceed a 30-day supply for retail pharmacies and up to a 90-day supply for Formulary maintenance medications only through the mail order program.

The pharmacist will collect the Copayment at the time the drugs are obtained. If the Participant requests a Brand Name Drug when a Generic Drug is available, the Participant is responsible for paying the entire cost of the Prescription. If the prescription specifies a Brand Name Drug and the prescribing Physician has written "Dispense as Written" or "Do Not Substitute" on the prescription, the drug will not be covered if use of the brand-name drug rather than the generic version is not Medically Necessary. .

Prescriptions may be refilled at Your local pharmacy after 75% of the medication has been used. Prescriptions being refilled through the mail order program may occur after 65% of the medication has been used.

Drug Coverage is based on the use of the Plan's Managed Formulary through PinnacleRx Solutions. Non-Formulary drugs may be covered subject to higher Copayments. Selected drugs and drug dosages may require prior authorization for Medical Necessity and appropriateness of therapy. Prenatal vitamins, Prilosec, Claritan and Zrytec, tobacco addiction treatment medications and their generic forms are Covered Expense when You use the pharmacy prescription drug card.

Formulary Drugs – Formulary Drugs are a comprehensive list of drugs maintained by PinnacleRx Solutions for use under the Plan. It is designed to assist Physicians in prescribing drugs that are Medically Necessary and cost effective. Medications are selected for inclusion in the Plan's managed drug Formulary based upon safety, efficacy, FDA bioequivalency data, and then cost. New drugs and clinical data are reviewed regularly to update the Formulary. Drugs considered for inclusion or exclusion from the Formulary are reviewed by PinnacleRx Solutions.

Non-Formulary Drugs – Non-Formulary Drugs are determined by PinnacleRx Solutions as being duplicative or as having preferred Formulary drug alternatives available. Benefits may be provided for Non-Formulary drugs and are always subject to the Non-Formulary Copayment.

Brand Name Drugs – Brand Name Drugs are FDA approved drugs under patent to the original manufacturer and only available under the original manufacturer's branded name.

Specialty Oral Drugs – Are drugs that are determined by PinnacleRx Solutions. These drugs are for the specific treatment of certain debilitating and life-threatening illnesses.

Specialty Self-Injectables - These drugs are for the specific self-treatment of certain debilitating and life-threatening illnesses. (See Note).

Note: Specialty drugs will be subject to the medical Plan's percentage payable and medical Deductible. A specialty drug is subject to the Plan Administrator's approval with PinnacleRx Solutions's recommendation.

Generic Drugs – Generic Drugs are drugs that are: 1) approved by the Food and Drug Administration (FDA) as safe and effective; 2) produced and sold under the chemical name after the original patent has expired; and 3) cost less than the Brand Name equivalent.

Claims for drugs obtained at a Participating Pharmacy without using the Prescription Drug Card should be submitted with the receipt and a completed Prescription Drug Claim Form to PinnacleRx Solution for reimbursement. PinnacleRx Solutions will reimburse the Participant for Covered medications according to the Negotiated Contract Rate less the applicable Copayment as indicated above. Claims must be received within six months from the date of service to be considered.

Mail Order Program - All provisions of the Prescription Drug Card apply to the Mail Order program except for the Copayment amount. If the medication is not on the Maintenance Formulary, then the medication will not be covered. Mail Service prescription drugs are limited to a quantity not to exceed a 90-day supply. If the Participant's Physician indicates a prescription quantity of less than a 90-day supply, that amount will be dispensed and refill authorizations cannot be combined to reach a 90-day supply.

Expenses Not Covered

In addition to the Pharmacy Vendor Prescription Program Terms of Agreement, prescription drug coverage will not include any of the following:

Administration: Any charge for the administration of a drug.

Blood, Blood Plasma & Biological Sera.

Cosmetic Products: Cosmetic-type drugs including photo-aged skin products such as Renova and Avage.

a) Hair growth agents such as Propecia and Vaniqa.

b) Injectable cosmetics such as Botox.

Equipment, Devices, Etc.: Devices of any type, except contraceptives, even though such devices may require a prescription. These include but are not limited to:

a) respiratory therapy supplies such as aerochambers or spacers;

b) peak flow meters;

c) non-insulin syringes; and

d) artificial appliances or braces.

Excess Refills: Refills which exceed the number of times specified by a Physician or which are dispensed more than one (1) year from the date of the Physician's prescription order.

Experimental & Non-FDA Approved Drugs: Experimental drug and medicines, even though a charge is made to the eligible Plan Participant. Any drug not approved by the Food and Drug Administration.

Hair Loss Drugs: see "Cosmetic Products."

Homeopathic Drugs: Homeopathic drugs, legend or non-legend.

Immunization Agents: Serums, toxoids or vaccines, unless expressly included in **Eligible Medical Expenses**.

Investigational Drugs: A drug or medicine labeled: "Caution – limited by federal law to investigational use."

No Charge: A prescribed drug which may be properly received without charge under a local, state or federal program or for which the cost is recoverable under any workers' compensation or occupational disease law.

Non-Home Use: Drugs intended for use in a health care facility (Hospital, Skilled Nursing Facility, etc.) or in Physician's office or setting other than home use.

Non-Prescription Drugs: A drug or medicine that can legally be bought without a written prescription. This does not apply to insulin.

OTC Equivalents: Products available "over-the-counter" (i.e., without a prescription) that are identical to prescription drugs in active chemical ingredient, dosage form, strength and route of administration, except those products identified in the prescription drug formulary.

Replacement Prescriptions: Replacement of a prescription that has been lost, except that replacement of one (1) lost prescription per year will be covered.

Applicable exclusions and limitations are also described in **Medical Limitations and Exclusions** and apply to the Prescription Drug Program, when applicable

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GENERAL EXCLUSIONS

The following exclusions apply to all health benefits and no benefits will be payable for:

Court-Ordered Care, Confinement or Treatment: Any care, confinement or treatment of a Covered Person in a public or private institution as the result of a court order, unless the treatment would have been covered in the absence of the court order.

Criminal Activities: Any injury resulting from or occurring during a Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation.

This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

Drugs in Testing Phases: Medicines or drugs that are in the Food and Drug Administration Phases I, II, or III testing, drugs that are not commercially available for purchase or are not approved by the Food and Drug Administration for general use, except as specifically described in Eligible Medical Expenses.

Excess Charges: Charges in excess of the Usual, Customary and Reasonable fees for services or supplies provided.

Experimental/Investigational Treatment: Expenses for treatments, procedures, devices, or drugs which the Plan determines, in the exercise of its discretion, are experimental, investigational, or done primarily for research. Treatments, procedures, devices, or drugs shall be excluded under this Plan unless:

- approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law; and
- reliable evidence shows that the treatment, procedure, device or drug is not the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses; and
- reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses.

"Reliable evidence" shall include anything determined to be such by the Plan, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the medical professional community in the United States, including the *CMS Medicare Coverage Issues Manual.*

Forms Completion: Charges made for the completion of claim forms or for providing supplemental information.

Government-Operated Facilities: Services furnished to the Covered Person in any veterans hospital, military hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments and for which the Covered Person has no legal obligation to pay.

NOTE: This exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government hospital to dependents of active duty armed service personnel or armed service retirees and their dependents. This exclusion does not apply where otherwise prohibited by law.

Late-Filed Claims: Claims that are not filed with the Contract Administrator for handling within the required time periods as included in the **Claims Procedures** section.

Military Service: Conditions that are determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

Missed Appointments: Expenses incurred for failure to keep a scheduled appointment.

No Charge/No Legal Requirement to Pay: Services for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. Where Medicare coverage is involved and this Plan is a "secondary" coverage, this exclusion will apply to those amounts a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts.

NOTE: This exclusion does not apply to any benefit or coverage that is available through the Medical Assistance Act (Medicaid).

Other Coverage: Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Payor or Medicaid Priority rules.

Services or supplies received from a health care department maintained by or on behalf of an employer, mutual benefit association, labor union, trustees or similar person(s) or group.

Outside United States: Charges incurred outside of the United States if the Covered Person traveled to such a location for the primary purpose of obtaining such services or supplies.

Postage, Shipping, Handling Charges, Etc.: Any postage, shipping or handling charges that may occur in the transmittal of information to the Contract Administrator. Interest or financing charges.

Prior Coverages: Services or supplies for which the Covered Person is eligible for benefits under the terms of the document that this SPD replaces.

Prior to Effective Date / After Termination Date: Charges incurred prior to an individual's effective date of coverage hereunder or after coverage is terminated, except as may be expressly stated.

Relative or Resident Care: Any service rendered to a Covered Person by a relative (i.e., a spouse, or a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

Sales Tax, Etc.: Sales or other taxes or charges imposed by any government or entity. However, this exclusion will not apply to surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) or similar surcharges imposed by other states.

Self-Inflicted Injury: Any expenses resulting from voluntary self-inflicted injury or voluntary attempted self-destruction, except that, this exclusion will not apply where such self-inflicted injury results from a medical condition (physical or mental), including a medical condition such as depression.

Travel: Travel or accommodation charges, whether or not recommended by a Physician, except for ambulance charges or as otherwise expressly included.

War or Active Duty: Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications therefrom, or service (past or present) in the armed forces of any country, to the extent not prohibited by law.

Work-Related Conditions: Any condition for which the Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose, whether or not a claim is made for such benefits. If the Plan provides benefits for any such condition, the Plan Sponsor will be entitled to establish a lien upon such other benefits up to the amount paid.

NOTE: This exclusion will **not** apply if the law does not permit the Covered Person or the Covered Person's employer to obtain coverage under a Workers' Compensation Act or similar law. Nor will it apply if the law permits but does not require a Covered Person who is a partner or an individual proprietor to have coverage under a Workers' Compensation Act or similar law and the person does not, in fact, have such coverage.

COORDINATION OF BENEFITS

It is not the intent of the Plan to reimburse for more than the allowable expenses. Benefits payable under the Plan will be coordinated with any other group health benefit coverage the Plan Participant, or eligible Dependents, may have. Coordination means that no more than one hundred percent (100%) of allowable expenses charged will be reimbursed under the combined benefits of all plans to which the patient is entitled.

Order of Benefit Determination

When any patient is covered under two or more health benefit plans, this Plan's rules for determining the order of benefit payments are as follows:

a) The plan that covers the patient as the "active employee" or "individual" will be the primary payor for that person for all benefits, including but not limited to medical, preventive, and prescription medication benefits.

b) If the patient is eligible as a retiree under one plan and an active employee under the other, the Plan covering the individual as an active employee will be primary.

c) If the patient is covered as an active employee under two or more plans, the plan having the earliest effective date will be primary.

d) If the patient is a dependent child, the benefits of the plan of the parent whose birthday falls earlier in a year are primary over the plan of the parent whose birthday falls later in the year. If the natural parents are divorced, the primary payor will be the plan of the custodial parent unless coverage for the dependent child is subject to a qualified Court Order; the secondary payor will be the plan covering any stepparent with whom the child is living and the plan covering the noncustodial natural parent will be last.

When this Plan is determined to be secondary payor, based on the rules shown above, covered expense does not include charges which would not have been billed to the patient in the absence of this benefit plan.

The intent of this provision is solely to maintain an orderly system of determining each carrier's liability. The Plan Participant or eligible Dependent's claim should be sent first to the primary payor, as determined by the above order. When notice of payment has been received from the primary payor, a copy of all bills and the explanation of benefits provided by the first payor should then be sent to the secondary carrier for coordinated payment.

No COB Provision: If an Other Plan does not contain a coordination of benefit provision, then the Other Plan will be primary and This Plan will be secondary.

Automobile Coverage: When medical benefits are available under vehicle insurance, This Plan will always be considered an excess (or secondary) coverage and will not reimburse vehicle plan deductibles. This applies without regard to an individual's election under PIP (personal Injury protection) coverage with an auto carrier. This Plan shall always be considered secondary and will coordinate with benefits provided or required by any no-fault insurance state, whether or not a no-fault policy is in effect, and/or any other carrier.

Facility of Payment: For purposes of coordination, this Plan reserves the right to: (a) release to or obtain from any other organization or individual any claim information which the Plan or the other benefit carrier may require; (b) recover any overpayment made under the Plan because of the eligible Plan Participant or eligible Dependent's failure to report other coverage when submitting a claim and the Plan's failure to consider that coverage when making payment; and, (c) to reimburse any other organization an amount this Plan determines to be warranted, if payments which should have been made under the Plan were made by the other organization.

When this Plan is the primary plan, benefits will be provided without considering the Other Plan(s). When this Plan is the secondary plan and there is a dispute as to which plan is primary, or the primary plan has not paid within a reasonable period of time, this Plan will provide benefits as if it were the primary plan.

Medicare as an "Other Plan": Medicare will be the primary, secondary or last payer in accordance with federal law. Benefits under this Plan will be integrated with any benefits payable under the federal Medicare

program. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan will make this determination based on the information available through CMS.

NOTE: An active Employee (or spouse) age sixty-five or older who is entitled to Medicare and who chooses to have Medicare as their primary carrier, may not also have coverage hereunder.

Medicaid Issues: Eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Person. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Plan Participant, as required by the State Medicaid program; and the Plan will honor any subrogation rights the State may have with respect to benefits which are payable under the Plan.

Disability Extensions: If a Covered Person is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

TRICARE: The Plan will pay primary to TRICARE and a State child health plan to the extent required by federal law.

Non-Dependent vs. Dependent: The benefits of a plan that covers the claimant other than as a dependent will be determined before the benefits of a plan that covers such claimant as a dependent. However, if the claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired Employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an Employee, member, subscriber or retiree is secondary and the other plan is primary.

Dual Coverage: When Spouses are both covered by this Plan the benefits are processed so that each is treated as a dependent under the other's plan. Their dependents shall likewise receive benefits from this Plan from both parents with the primary payor being whose birthday falls earlier in the year.

Child Covered Under More Than One Plan: When the claimant is a dependent Child, the primary plan is the plan of the parent whose birthday is earlier in the year if: (1) the Child's parents are married, (2) the parents are not separated, whether or not they have ever been married, or (3) a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

When the claimant is a dependent Child and the specific terms of a court decree state that one of the parents is responsible for the Child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Claim Determination Periods or plan years commencing after the plan is given notice of the court decree.

When the claimant is a dependent Child whose father and mother are not married, are separated (whether or not they have ever been married) or are divorced, the order of benefits is:

a) the plan of the Custodial Parent;

b) the plan of the spouse of the Custodial Parent;

c) the plan of the noncustodial parent; and then

d) the plan of the spouse of the noncustodial parent.

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

Active vs. Inactive Employee: The plan that covers the claimant as an employee who is neither laid off nor retired is primary. The plan that covers a person as a dependent of an employee who is neither laid off nor retired is primary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage (COBRA) Enrollee: If a claimant is a COBRA enrollee under this Plan, any other plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent)

is primary and this Plan is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer vs. Shorter Length of Coverage: If none of the above rules establish which plan is primary, the benefits of the plan that has covered the claimant for the longer period of time will be determined before those of the plan that has covered that person for the shorter period of time.

NOTE: If the preceding rules do not determine the primary plan, the Eligible Expenses shall be shared equally between this Plan and the other Plan(s). However, this Plan will not pay more than it would have paid had it been primary.

Other Information About Coordination Of Benefits

Right to Receive and Release Necessary Information: For the purpose of enforcing or determining the applicability of the terms of this COB section or any similar provision of any other plan, the Plan Administrator may, without the consent of any person, release to or obtain from any insurance company, organization or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish to the Plan Administrator such information as may be necessary to enforce this provision.

Facility of Payment: A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

Right of Recovery: In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Eligible Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of these provisions, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the eligible Plan Participant or his or her Dependents. Please see the Recovery of Payments provision within the Claims Procedures section for more details.

SUBROGATION AND REIMBURSEMENT PROVISIONS

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an Injury, Sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of eligible Plan Participants, Plan Beneficiaries, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Participant(s)") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "Coverage").

Eligible Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the eligible Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the eligible Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The eligible Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event an eligible Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the eligible Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the eligible Plan Participant(s). If the eligible Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the eligible Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the eligible Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the eligible Plan Participant(s) agrees to subrogate the Plan to any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the eligible Plan Participant(s) is entitled, regardless of how classified or characterized.

If an eligible Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any eligible Plan Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may in its own name or in the name of the eligible Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the eligible Plan Participant(s) fails to file a claim or pursue damages against:

- the responsible party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;
- worker's compensation or other liability insurance company; or
- any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

- the eligible Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the eligible Plan Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The eligible Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the eligible Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable subrogation lien. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the eligible Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the eligible Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the eligible Plan Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, disease or disability.

Excess Insurance: If at the time of Injury, Sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the **Coordination of Benefits** section.

The Plan's benefits shall be excess to:

- the responsible party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;
- worker's compensation or other liability insurance company; or
- any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds: Benefits paid by the Plan, funds recovered by the eligible Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the eligible Plan Participant(s), such that the death of the eligible Plan Participant(s), or filing of bankruptcy by the eligible Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death: In the event that the eligible Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the eligible Plan Participant(s) and all others that benefit from such payment eligible Plan Participant.

Obligations: It is the eligible Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

- to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
- to provide the Plan with pertinent information regarding the Sickness, disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;
- to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

If the eligible Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the eligible Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the eligible Plan Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the eligible Plan Participant(s)' cooperation or adherence to these terms.

Offset: Failure by the eligible Plan Participant(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the eligible Plan Participant(s) satisfies his or her obligation.

Minor Status: In the event the eligible Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation: The Plan Sponsor retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Sponsor may amend the Plan at any time without notice.

Severability: In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility Requirements - Employees

A Permanent Full-time, a Part-time (20 hours or more per week) Employee, and a Certificated Adult Education Teacher, under the definitions below are eligible to apply their TUSD paid fringe benefits towards the cost of their health package. These Employees may be required to contribute to the cost of their health package if their health elections exceed the amount of the TUSD paid fringe contribution. A Part-time Employee (less than 20 hours per week) is eligible for benefits as defined below, and is required to pay for the cost of their health package, as there are no TUSD paid fringe contributions for this class of employees. Dependent coverage is available to all qualified Dependents at the Employee's expense. Additionally, the Employee must meet the District's standard minimum eligibility requirements for fringe benefits due to either contractual language or District policy and submit an enrollment application on behalf of himself/herself.

Permanent & Full-time Employee: All permanent and full-time employees are eligible for a TUSD contribution towards fringe benefits.

Permanent & Part-time (20 hours or more per week) Employees: All classified permanent and part-time employees who work 20 hours or more per week in one classification, or certified (excluding Adult Education, see below) permanent and part-time employees who have a signed contract for at least 50% are eligible for TUSD contribution towards fringe benefits at a pro-rated amount based on the number of hours worked.

Certificated Adult Education Teachers: Adult Education Teachers qualify for a TUSD contribution towards fringe benefits when they work in a regularly scheduled assignment for 14 hours or more per week. Full-time for Adult Education Teachers is 28 hours per week. TUSD fringe benefits are pro-rated on the number of hours worked for employees who work less than Full-time, but at least 14 hours per week.

Part-time Employees (less than 20 hours per week): Part-time employees (less than 20 hours per week) who work at least 10 hours per week are eligible to enroll in medical, dental, and/or vision insurance. **The Part-time employee (less than 20 hours per week) pays all premiums**. Enrollment for core benefits (medical, dental, and/or vision) is open for a period of 30 days starting from the date you qualify for self-pay (working ten hours per week) benefits. There is also an Open Enrollment period each year during the month of August.

See **Extension of Coverage** section(s) for instances when these eligibility requirements may be waived or modified.

NOTE: Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

Effective Date - Employees

Waiting Period: An Eligible Employee's coverage is effective, subject to timely enrollment, upon completion of the following period:

- For newly-hired employees who work 12 calendar months (i.e., are hired at the beginning of the Plan Year), coverage begins the first of the month following the date of hire.
- For newly-hired employees who work 11 calendar months, coverage begins the first of the month following the date of hire.
- If an employee is hired in July or August, a monthly prorated premium will be assessed for the month(s) of August and September respectively.

If an eligible Employee fails to enroll within thirty (30) days after the earliest date his coverage could have been effective, his coverage can become effective only in accordance with the "Open Enrollment" or "Special Enrollment Rights" provisions below.

Eligibility Requirements - Dependents

Except as noted at the end of this provision, an eligible Dependent of an Employee is:

a) a legally married spouse. A "spouse" will mean a person of the opposite or the same sex possessing a marriage license who is not divorced from the Employee. "Married" will not include a common law spouse;

b) a "registered domestic partner" or "domestic partner" will mean an adult dependent of the opposite sex or the same sex Employee, possessing a conformed copy of Declaration of Domestic Partnership from the Secretary of State in California or such proof of validation required under the laws on another jurisdiction in the United States. See Definitions for specific requirements to establish a Domestic Partnership; or

c) a Child who is under age twenty-six (26) (i.e., through age twenty-five (25)). The Child need not: (1) reside with the Employee or any other person, (2) be a student, (3) be a tax-code dependent of the Employee or financially dependent on the Employee or any other person, (4) be unmarried, or (5) be unemployed.

An eligible "Child" is one who has a relationship with the Employee (e.g., a son, daughter, stepson or stepdaughter of the Employee, a legally adopted Child, a Child who is placed with the Employee for legal adoption, or a Child under the legal guardianship of the Employee). An eligible Child also includes one for whom coverage is required due to a Qualified Medical Child Support Order.

The Plan Administrator reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship.

An eligible Dependent does not include:

a) a spouse following a final decree of dissolution of marriage or divorce (including any children of the spouse who were eligible only because of the marriage);

b) any person who is on active duty in any military service, except where eligibility is required by U.S. law;

c) the child of a Dependent Child; or

d) the spouse of a Dependent Child.

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.

Qualified Medical Child Support Orders

The Plan Administrator shall enroll for immediate coverage under this Plan any child of a Plan Participant who is recognized under a Medical Child Support Order that is "Qualified" according to the procedures listed herein as having a right to enrollment under this Plan as the Plan Participant's eligible Dependent.

"Medical Child Support Order" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or

2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"National Medical Support Notice" or **"NMSN"** shall mean a notice that contains the following information:

1. Name of an issuing State agency;

2. Name and mailing address (if any) of an employee who is a Participant under the Plan;

3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and

4. Identity of an underlying child support order.

"Qualified Medical Child Support Order" or **"QMCSO"** is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;

2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;

3. The period of coverage to which the order pertains; and

4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";

2. a. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;

   b. Informs the Plan Administrator that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and

3. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and Eligible Plan Participants without regard to this section, except to the extent necessary to meet the requirements of a State law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822)

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Participant and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and

2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator shall, as soon as administratively possible:

1. Notify the State agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:

   a. Whether the child is covered under the Plan; and

   b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage; and

2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and

2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

Newborn and Newly-Adopted Children

Benefits will be payable under this Plan for thirty-one (31) days after the birth or adoption of the child. However, the Employee must contact the Benefits Department within thirty-one (31) days after the birth or adoption of the child to enroll the child in the Plan.

Effective Date - Dependents

Dependents who are eligible and enrolled concurrently with the Plan Participant will have coverage effective on the Plan Participant's coverage effective date. Coverage for Dependents acquired later will be effective on the first day of the month following the date they become eligible.

NOTE: In no instance will a Dependent's coverage become effective prior to the Plan Participant's coverage effective date.

Enrollment

Open Enrollment

If an individual does not enroll when he or she is first eligible to do so or if he or she allows coverage to lapse, he or she may later enroll during an Open Enrollment period that will be held annually from August 1st through August 31st. Plan coverage will be effective on the 1st day of October following the Open Enrollment period.

Eligible Plan Participant will receive detailed information regarding open enrollment from their Employer.

Special Enrollment Periods

Eligible Dependents acquired after your Effective Date will be qualified on the date of marriage, birth, adoption or legal placement. Coverage for newborns is provided from the date of birth if proper enrollment is completed within thirty (30) days of birth. The Employee must advise the Benefits Department within thirty (30) days of acquiring a new Dependent.

In no event will Dependent coverage become effective at a time when the Employee is not covered for the corresponding Employee coverage.

Special Enrollment Rights – The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009

Employees and dependents who are eligible but not enrolled for coverage in the Plan may enroll upon termination of the employee or dependent's Medicaid or CHIP coverage or if the employee or dependent become eligible for a premium assistance subsidy under Medicaid or CHIP. In both instances, the employee

must request coverage under the Plan, in writing, within 60 days after the termination or determination of subsidy eligibility.

Reinstatement / Rehire

If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Participating Employer's guidelines, and during the leave Employee discontinued paying his share of the cost of coverage (when applicable), such Employee may have coverage reinstated as if there had been no lapse (for himself and any Dependents who were covered at the point contributions ceased).

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain Employees who return to active employment following active duty service as a member of the United States armed forces, will be reinstated to coverage hereunder immediately upon returning from military service. See "Extension of Coverage During U.S. Military Service" in the Extensions of Coverage section for more information.

If an Employee or Dependent returns to an eligible status after having experienced a "Qualifying Event" and having continued Plan coverage, without interruption, as a "Qualified Beneficiary" under the terms of the COBRA Continuation Coverage, such person will be reinstated to active status and will have uninterrupted coverage hereunder.

NOTES: Except in the above instances, any terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements.

Transfer of Coverage

If both members of a married couple are Employees and are covered as Plan Participants under this Plan and one of them terminates, the terminating spouse and any of his or her eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such transferred coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

If an eligible Plan Participant changes status from Employee to Dependent or vice versa, and the person remains eligible and covered without interruption, then Plan benefits will not be affected by the person's change in status.

Dual Coverage

When a married couple are each enrolled for coverage as Employees under this Plan, each has the option to enroll eligible Dependents for coverage hereunder. If both Spouses are employed with TUSD and are eligible for TUSD fringe benefits, they have the option of combining both fringe benefit contributions together and apply for family coverage. The combined maximum contractual benefits to which both Employees are entitled hereunder will not exceed the aggregate of 100 percent of the Usual, Customary and Reasonable charge(s) for the Covered Expense(s). See **Coordination of Benefits** section for claims handling procedures.

TERMINATION OF COVERAGE

Employee Coverage Termination

Except as noted, a Plan Participant's coverage will terminate upon the earliest of the following:

a) termination of the Plan or Plan benefits as described herein;

b) Participating Employer's election to terminate these Plan benefits, unless prohibited by law;

c) At midnight on the last day of the month in which the Plan Participant fails to pay the required contribution (includes contributions owed during leave of absence);

d) at midnight on the last day of the month in which the Plan Participant leaves or is dismissed from the employment of the Participating Employer, ceases to be eligible, or ceases to be engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the **Extensions of Coverage** section; or

e) the date of the month following the date of the Plan Participant's death.

See also "Termination for Fraud" in the **Miscellaneous Provisions** section.

NOTE: Unused vacation days or severance pay following cessation of active work will not count as extending the period of time coverage will remain in effect.

A Plan Participant otherwise eligible and validly enrolled hereunder shall not be terminated solely due to his health status or need for health services.

Dependent Coverage Termination

Except as noted, a Dependent's coverage will terminate upon the earliest of the following:

a) termination of the Plan or these Plan benefits or discontinuance of Dependent coverage hereunder;

b) at midnight on the last day of the month in which the Employee fails to pay the required contribution or otherwise is ineligible for the Plan benefits;

c) at midnight on the last day of the month in which the Dependent ceases to meet the eligibility requirements of these Plan benefits, except when coverage is extended under the Extensions of Coverage section. A Plan Participant's adoptive Child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the Child is removed from placement with the Plan Participant;

d) at midnight on the last day of the month in which the Plan Participant requests that Dependent coverage be terminated unless prohibited by law (i.e., when election changes cannot be made due to IRC section 125 "change in status" guidelines). However, in the case of a Child covered due to a Qualified Medical Child Support Order (QMCSO), the Plan Participant must provide proof that the Child support order is no longer in effect or that the Dependent has comparable replacement coverage that is in effect or will take effect immediately upon termination; or

e) the date following the Dependent death.

See also "Termination for Fraud" in the **Miscellaneous Provisions** section.

NOTE: A Dependent otherwise eligible and validly enrolled hereunder shall not be terminated solely due to his health status or need for health services.

- (*See **COBRA Continuation Coverage***) -

EXTENSIONS OF COVERAGE

Coverage may be continued beyond the **Termination of Coverage** date in the circumstances identified below. Unless expressly stated otherwise, however, coverage for a Dependent will not extend beyond the date the Plan Participant's coverage ceases.

Extension of Coverage for Developmentally Disabled or Handicapped Dependent Children

If an already covered Dependent Child is incapable of self-sustaining employment by reason of intellectual disability or physical disability or handicap, and:

a) such condition commenced on or before the Child attained an age that would otherwise terminate his eligibility;

b) the Child's condition has been diagnosed by a Physician as a permanent or long-term dysfunction or condition; and

c) such Child is primarily dependent upon the Plan Participant for support and maintenance;

then such Child's status as a "Dependent" will continue, irrespective of his attaining a limiting age, so long as he remains in such condition, and otherwise conforms to the definition of "Dependent."

The Plan Participant must submit proof of the Child's incapacity to the Contract Administrator within thirty (30) days of the Child's attainment of a limiting age, and as may reasonably be required thereafter, but not more frequently than once a year.

Extensions of Coverage During Absence From Work

If a Plan Participant fails to continue in active employment but is not terminated from employment (e.g., he is absent due to an approved leave, a temporary layoff, or is eligible for an extension required by law, etc.), he may be permitted to continue health care coverages for himself and his Dependents though he could be required to pay the full cost of coverage during such absence. Any such extended coverage allowances will be provided on a non-discriminatory basis.

Leave of Absence

Family Medical Leave Act ("FMLA")

To the extent that the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), it intends to comply with the Act. The Employer is subject to FMLA if it is engaged in commerce or in any industry or activity affecting commerce and employs fifty (50) or more employees for each working day during each of twenty (20) or more calendar workweeks in the current or preceding Calendar Year.

In accordance with the FMLA, a Plan Participant is entitled to continued coverage if he: (1) has worked for the Employer for at least twelve months, (2) has worked at least 1,250 hours in the year preceding the start of the leave, and (3) is employed at a worksite where the Employer employs at least fifty employees within a 75-mile radius.

Except as noted, continued coverage under the FMLA is allowed for up to 12 workweeks of unpaid leave in any 12-month period. Such leave must be for one or more of the following reasons:

- the birth of an Employee's child and in order to care for the child;
- the placement of a child with the Employee for adoption or foster care;
- to care for a spouse, child or parent of the Employee where such relative has a serious health condition;
- Employee's own serious health condition that makes him/her unable to perform the functions of his or her job; or
- the Employee has a "qualifying exigency" (as defined by DOL regulations) arising because the Employee's spouse, son, daughter or parent is on active duty (or has been notified of an

impending call or order to active duty) in the Armed Forces in support of a contingency operation (a specified military operation).

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. During any unpaid portion of your leave of absence, you will be responsible for paying your portion of the benefit cost share. Failure to so could result in termination of benefits unless stipulated otherwise by federal or state law. If benefits are terminated, the Participant and eligible dependents will be provided with notification of eligibility through COBRA. The above is a summary of FMLA requirements. An Employee can obtain a more complete description of his FMLA rights from the Plan Sponsor's Human Resources or Personnel department. Any Plan provisions which are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

NOTE: An eligible Employee will be entitled to take up to a combined total of 26 workweeks of FMLA leave during a single 12-month period where the Employee is a spouse, son, daughter, parent or next of kin (i.e., nearest blood relative) of a covered service member. A "covered service member" is a member of the Armed Forces (including the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is an outpatient, or is on the temporary disability retired list, for a "serious injury or illness" (an injury or illness incurred in line of duty on active duty in the Armed Forces that may render the service member medically unfit to perform his or her duties).

Extension of Coverage During U.S. Military Service

Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

A Plan Participant who is ordered to active military service is (and the Plan Participant's eligible Dependent(s) are) considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the stipulations set forth herein.

Notice Requirements - To be protected by USERRA and to continue health coverage, a Plan Participant must generally provide the Employer with advance notice of his military service. Notice may be written or oral, or may be given by an appropriate officer of the military branch in which the Plan Participant will be serving. Notice will not be required to the extent that military necessity prevents the giving of notice or if the giving of notice is otherwise impossible or unreasonable under the relevant circumstances. If the Plan Participant's ability to give advance notice was impossible, unreasonable or precluded by military necessity, then the eligible Employee may elect to continue coverage at the first available moment and will be retroactively reinstated in the Plan to the last day of active employment before leaving for active military service. The eligible Employee will be responsible for payment of all back contributions from date of termination of Plan coverage. No administrative or reinstatement charges will be imposed.

If the Plan Participant provides the Employer with advance notice of his military service but fails to elect continuation of coverage under USERRA, the Plan Sponsor will continue coverage for the first thirty (30) days after the Plan Participant's departure from employment due to active military service. The Plan Sponsor will terminate coverage if eligible Employee's notice to elect coverage is not received by the end of the thirty (30)-day period. If the eligible Employee subsequently elects to continue coverage while on active military service and within the time set forth in the subsection entitled "Maximum Period of Coverage" below, then the eligible Employee will be retroactively reinstated in the Plan as of the last day of active employment before leaving for active military service. The eligible Employee will be responsible for payment of all back contribution charges from the date Plan coverage terminated.

Cost of USERRA Continuation Coverage - The Plan Participant must pay the cost of coverage (herein "contribution"). The contribution may not exceed 102% of the actual cost of coverage, and may not exceed the active eligible Employee's cost share if the military leave is less than thirty-one (31) days. If the Plan Participant fails to make timely payment within the same time period applicable to those enrollees of the plan continuing coverage under COBRA, the Plan Sponsor will terminate the Plan Participant's coverage at the end of the month for which the last contribution payment was made. If the Employee applies for reinstatement to the Plan while still on active military service and otherwise meets the requirements of the Plan and of USERRA, the Plan Sponsor will reinstate the eligible Employee to Plan coverage retroactive

to the last day the contribution was paid. The eligible Employee will be responsible for payment of all back contribution charges owed.

Maximum Period of Coverage - The maximum period of USERRA continuation coverage is the lesser of:

- Twenty-four (24) months; or
- the duration of the eligible Employee's active military service.

Reinstatement of Coverage Following Active Duty - Regardless of whether a Plan Participant elects continuation coverage under USERRA, coverage will be reinstated on the first day the eligible Employee returns to active employment if the eligible Employee was released under honorable conditions.

An Employee returning from military leave must notify their Employer of their intent to return to work. Notification (application for reemployment) must be made:

- within fourteen (14) days of completion of military service for military leave of thirty-one (31) through one-hundred eighty (180) days; or
- within ninety (90) days of completion of military service for military leave of more than one-hundred eighty (180) days.

No reemployment application is required if the military leave is less than thirty-one (31) days. In that case, generally the Employee need only report for work on the next regularly scheduled workday after a reasonable period for travel and rest. Uniformed Service members who are unable to report back to work because they are in the hospital or recovering from an Injury or Illness suffered during active duty have up to two (2) years to apply for reemployment.

When coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the Plan Participant had not taken military leave and coverage had been continuous. No waiting period can be imposed on a returning Employee or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

California Family Rights Act ("CFRA")

All the terms and conditions of the FMLA apply. CFRA provides a leave of absence to bond with a newborn or adoption. This leave of absence must be approved by the employer and runs concurrent with the FMLA.

California Pregnancy Disability Act ("CPDL")

On an approved pregnancy leave of absence the Plan will continue benefits for up to four months. This leave of absence must be approved by the employer and runs concurrent with the FMLA. All the terms and conditions of the FMLA apply. You will be responsible for paying your portion of the benefit cost share during the pregnancy leave of absence.

Organ Donor (Michelle Maykin Memorial Protection Act)

If the Employee is granted a leave of absence under the Michelle Maykin Memorial Act (California Labor Code Section 1508) health Plan benefits will be maintained for up to 30 days for organ transplant and up to five business days for bone marrow transplant.

EXTENSION OF BENEFITS DURING TOTAL DISABILITY

If, on the date coverage terminates (as determined by the Termination of Coverage section), an Employee or Dependent is Totally Disabled, benefits will be extended but only for the condition causing such Total Disability and only during the uninterrupted continuance of that disability. Extended benefits under the terms of this provision will terminate on the earlier of the following:

1. upon termination of the Total Disability;
2. twelve (12) months following the date coverage terminated;
3. upon the individual's eligibility for coverage in any other group plan, self-insured plan, prepayment plan, HMO or government plan that does not limit coverage for the disabling condition;
4. upon termination of the Plan;
5. the last day of the month for which any required contributions for extended benefits has not been paid.

If benefits are extended, the employee will be responsible for the entire cost of coverage. No further contributions will be made by the employer.

With reference to an Employee, "Total Disability" or "Totally Disabled " means a disability resulting solely from a sickness, injury or pregnancy that prevents the Employee from performing every duty pertaining to his or her occupation or engaging in any other type of work for remuneration. For a Dependent, it is disability that prevents Dependent from engaging in substantially all the normal activities of a person in good health of like age and sex.

A Physician (MD or DO) must certify an Employee or Dependent as Totally Disabled. Also, the individual must be under the care of a Physician (MD or DO) in order to be Totally Disabled for Plan purposes.

NOTE: If a Covered Person is eligible for and elects COBRA continuation coverage under the terms of the section entitled COBRA Continuation Coverage, coverage will be provided for ALL CONDITIONS and not just the disabling condition. However, this Extension of Benefits will run concurrently with such COBRA coverage and WILL NOT operate to extend the COBRA maximum period.

- *(See **COBRA Continuation Coverage**)* -

CLAIMS PROCEDURES

It is the intent of the Plan Sponsor that the following claims procedures comply with the United States Department of Labor ("DOL") regulation, 29 CFR § 2560.503-1. Where any provision is in conflict with the DOL's claims procedure regulations or any other applicable law, such law shall control.

Submitting A Claim

A claim is a request for a benefit determination which is made, in accordance with the Plan's procedures, by a Claimant or his authorized representative. A claim must be received by the person or organizational unit customarily responsible for handling benefit matters on behalf of the Plan so that the claim review and benefit determination process can begin. A claim must name the Plan, a specific Claimant, a specific treatment, service or supply (or procedure/revenue codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services are received, and provider name, address, phone number and tax identification number.

For purposes of the Plan, the Plan Sponsor, at its discretion, may contract with other entities to handle claims communications and benefit determinations for the Plan.

Assignments To Providers

All Eligible Expenses reimbursable hereunder will be paid to the Covered Person except that: (1) assignments of benefits to Physicians or other providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, within the time limits for filing proof of loss, and (3) the Plan may make benefit payments for a Child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such Child.

Benefits due to any In-Network provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

No Covered Person may, at any time, either while covered under the Plan or following termination of coverage, assign his right to sue to recover benefits under the Plan, or enforce rights due under the Plan or any other causes of action that he may have against the Plan or its fiduciaries.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

- Pre-service Claims. A "pre-service claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. This Plan does **not** require the Covered Person to obtain approval prior to getting treatment.
- Concurrent Claims. A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:
    - The Plan Sponsor determines that the course of treatment should be reduced or terminated; or
    - The Covered Person requests extension of the course of treatment beyond that which the Plan Sponsor has approved.

  This Plan does **not** require the Covered Person to obtain approval of a medical service prior to getting treatment.
- Post-service Claims. A "post-service claim" is a claim for a benefit under the Plan after the services have been rendered.

NOTE: In accordance with federal law, the Centers for Medicare and Medicaid Services (CMS) have three (3) years to submit claims when Medicare has paid as the primary plan and the Plan should have been primary.

When Health Claims Must Be Filed

Post-service health claims must be filed with the Contract Administrator within twelve (12) months of the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. Claims filed later than that date shall be denied.

A Post-Service Claim should be submitted to:

Pinnacle Claims Management, Inc.
P. 0. Box 2220
Newport Beach, CA 92658

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Contract Administrator in accordance with the Plan's procedures.

Notification of an Adverse Benefit Determination

The Plan Sponsor shall provide a Covered Person with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice). The notice will contain the following information:

- information sufficient to allow the Covered Person to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- a reference to the specific portion(s) of the plan provisions upon which a denial is based;
- specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
- a description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;
- a description of the Plan's internal appeals and external review processes and the time limits applicable to the processes. This description will include information on how to initiate the appeal following an Adverse Benefit Determination on final review;
- a statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Covered Person's claim for benefits;
- the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Covered Person, free of charge, upon request;
- in the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Covered Person, free of charge, upon request;
- information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes; and
- in a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Covered Person believes the claim has been denied wrongly, the Covered Person may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Covered Person with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

- Covered Persons at least one-hundred eighty (180) days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;
- Covered Persons the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- Covered Persons the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process;
- for a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
- for a review that takes into account all comments, documents, records, and other information submitted by the Covered Person relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
- that, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;
- for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;
- that a Covered Person will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim in possession of the Plan Sponsor or Contract Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Covered Person's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances; and
- that a Covered Person will be provided, free of charge, and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Covered Person to respond to such new evidence or rationale.

Requirements for Appeal

The Covered Person must file the appeal in writing (although oral appeals are permitted for preservice urgent care claims) within one-hundred eighty (180) days following receipt of the notice of an Adverse Benefit Determination. For pre-service urgent care claims, if the Covered Person chooses to orally appeal, the Covered Person may telephone:

Pinnacle Claims Management, Inc.
P. 0. Box 2220
Newport Beach, CA 92658
(800) 649-9121

To file an appeal in writing, the Covered Person's appeal must be addressed and mailed as follows:

Pinnacle Claims Management, Inc.
P. 0. Box 2220
Newport Beach, CA 92658
(800) 649-9121

It shall be the responsibility of the Covered Person to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- the name of the Plan Participant/Covered Person;
- the Plan Participant/Covered Person's social security number;
- the group name or identification number;
- all facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived.
- a statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- any material or information that the Covered Person has which indicates that the Covered Person is entitled to benefits under the Plan.

If the Covered Person provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review

The Plan Sponsor shall notify the Covered Person of the Plan's benefit determination on review within the following timeframes:

Pre-service Urgent Care Claims

If the eligible Plan Participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim.

If the eligible Plan Participant has not provided all of the information needed to process the claim, then the eligible Plan Participant will be notified as to what specific information is needed as soon as possible, but not later than seventy-two (72) hours after receipt of the claim.

The eligible Plan Participant will be notified of a determination of benefits as soon as possible, but not later than seventy-two (72) hours, taking into account the medical exigencies, after the earliest of:

- the Plan's receipt of the specified information; or
- the end of the period afforded the eligible Plan Participant to provide the information.

If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the eligible Plan Participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the eligible Plan Participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the eligible Plan Participant may request an expedited review under the external review process.

Pre-service Non-urgent Care Claims

If the eligible Plan Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15)-day extension period.

If the eligible Plan Participant has not provided all of the information needed to process the claim, then the eligible Plan Participant will be notified as to what specific information is needed as soon as possible, but not later than five (5) days after receipt of the claim. The eligible Plan Participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of

the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Sponsor and the eligible Plan Participant (if additional information was requested during the extension period).

Post-service Claims

Within a reasonable period of time, but not later than sixty (60) days after receipt of the appeal.

Calculating Time Periods

The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Concurrent Claims

Plan Notice of Reduction or Termination. If the Plan Sponsor is notifying the eligible Plan Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The eligible Plan Participant will be notified sufficiently in advance of the reduction or termination to allow the eligible Plan Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

Request by Eligible Plan Participant Involving Urgent Care. If the Plan Sponsor receives a request from an Eligible Plan Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim, as long as the eligible Plan Participant makes the request at least seventy-two (72) hours prior to the expiration of the prescribed period of time or number of treatments. If the eligible Plan Participant submits the request with less than twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

Request by Eligible Plan Participant Involving Non-urgent Care. If the Plan Sponsor receives a request from the eligible Plan Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).

Request by Eligible Plan Participant Involving Rescission. With respect to rescissions, the following timetable applies:

Notification to Eligible Plan Participant	thirty (30) days
Notification of Adverse Benefit Determination on appeal	thirty (30) days

Post-service Claims

If the eligible Plan Participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than thirty (30) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15)-day extension period.

If the eligible Plan Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the eligible Plan Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the eligible Plan Participant will be notified of the determination by a date agreed to by the Plan Sponsor and the eligible Plan Participant.

Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Sponsor shall provide a Covered Person with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

- information sufficient to allow the Covered Person to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- a reference to the specific portion(s) of the plan provisions upon which a denial is based;
- specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;
- a description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;
- a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
- a description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal following an Adverse Benefit Determination on final review;
- a statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits;
- the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Covered Person, free of charge, upon request;
- in the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Covered Person, free of charge, upon request; and
- the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Sponsor shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review

If, for any reason, the Covered Person does not receive a written response to the appeal within the appropriate time period set forth above, the Covered Person may assume that the appeal has been denied. The decision by the Plan Sponsor or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

When the Named Fiduciary is a Committee or Board of Trustees

If the Plan's Named Fiduciary is a committee or board of trustees that holds regularly-scheduled meetings at least quarterly, the Named Fiduciary shall make a benefit determination not later than the meeting date that immediately follows the Plan's receipt of an appeal, unless the appeal is filed within thirty (30) days preceding the date of such meeting. In that case, a benefit determination may be made not later than the date of the second meeting following the Plan's receipt of the appeal. If special circumstances (such as the need to hold a hearing as is permitted by the Plan) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting following the Plan's receipt of the appeal. If such an extension of time for review is required because of special circumstances, the Plan Participant will be provided with written notice of the extension describing the special circumstances and the date on which the benefit determination will be made. Such notice will be provided prior to the commencement of the extension. When benefit determination is made, notice of the decision will be provided to the Plan Participant not later than five (5) days thereafter.

External Review Process

The Federal external review process does **not** apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Covered Person fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process applies only to:

- an Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and
- a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Request for external review

The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Preliminary review

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

- the claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- the Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
- the claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and
- the claimant has provided all the information and forms required to process an external review. Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the

request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the forty-eight (48) hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization

The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

Reversal of Plan's decision

Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Referral to independent review organization

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

Notice of final external review decision

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

DEFINITIONS

When capitalized herein, the following items will have the meanings shown below.

Abortion: Shall mean induced termination of a pregnancy at the election of the Participant. A therapeutic Abortion is the induced termination of a pregnancy by any acceptable means medically indicated by a diagnosis affecting the mental or physical health of the mother.

Accidental Injury: Any accidental bodily Injury that is caused by external forces under unexpected circumstances and that is not excluded due to being employment-related (see **General Exclusions** section). Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Accidental Injury for purposes of benefit determination.

An Accidental Injury will also include injuries suffered by an eligible Plan Participant who is the victim of domestic violence.

Acupuncture: A technique used to deliver anesthesia or analgesia, or for treating conditions of the body (when clinical efficacy has been established for treatment of such conditions), by passing long, thin needles through the skin. This care is rendered by, referred or prescribed by a licensed Acupuncturist.

Adverse Benefit Determination: Any of the following:

a) a denial in benefits;

b) a reduction in benefits;

c) a rescission of coverage;

d) a termination of benefits; or

e) a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

AHA: The American Hospital Association.

Ambulatory Surgical Center: Any public or private establishment that:

- complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;
- has an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
- provides continuous Physician services and registered professional nursing services whenever a patient is in the facility; and
- does not provide services or other accommodations for patients to stay overnight.

AMA: The American Medical Association.

Appeal: A request to have a decision by the Plan reviewed and reconsidered.

Approved Clinical Trial: A phase I, II, III or IV trial that is federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, CMS, Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an investigational new drug application reviewed by the FDA (if such application is required).

Effective January 1, 2014, the Patient Protection and Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

An Approved Clinical Trial will be covered under the Plan if the Plan Participant is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the participant provides medical and scientific information establishing that his or her participation is appropriate.

Routine patient costs are covered under the Plan. Routine patient costs include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's network area unless Out-of-Network benefits are otherwise provided under the Plan.

Assignment of Benefits: An arrangement whereby the eligible Plan Participant assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of an eligible Plan Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowable expense. For example, if the provider's charge is $100 and the allowable expense is $70, the provider may bill you for the remaining $30. A Participating Provider may not balance bill you for covered services.

Birthing Center: A special room in a Hospital that exists to provide delivery and pre-natal and post-natal care with minimum medical intervention or a free-standing Outpatient facility that:

a) is in compliance with licensing and other legal requirements in the jurisdiction where it is located;

b) is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients;

c) has organized facilities for birth services on its premises;

d) provides birth services by or under the direction of a Physician specializing in obstetrics and gynecology;

e) has twenty-four (24)-hour-a-day registered nursing services; and

f) maintains daily clinical records.

Brand Name Drug: Drugs produced and marketed exclusively by a particular manufacturer.

Calendar Year: The period of time commencing at 12:01 A.M. on January 1 of each year and ending at 12:01 A.M. on the next succeeding January 1. Each succeeding like period will be considered a new Calendar Year.

Cardiac Care Unit: A separate, clearly designated service area which is maintained within a Hospital and which meets all of the following requirements:

a) it is solely for the treatment of patients who require special medical attention because of their critical condition;

b) it provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;

c) it provides a concentration of special lifesaving equipment immediately available within such area;

d) it contains at least two beds for the accommodation of critically ill patients; and

e) it provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a twenty-four (24)-hour-a-day basis.

Charitable Research Hospital: A Hospital that:

a) Is internationally recognized as devoting itself primarily to medical research;

b) expends not less than 10% of its operating budget in each fiscal year exclusively on medical research activities that are not directly related to the provision of services to patients;

c) derives not less than one-third (1/3) of its gross revenues in each fiscal year from contributions, donations, grants, gifts, or other gratuitous forms from individuals, groups, persons, or entities unrelated to the hospital. Contributions, donations, grants, gifts, or other gratuitous sources of revenue received as compensation for medical services provided to patients will not be considered for these purposes;

d) accepts patients without regard to the patient's ability to pay for medical services;

e) admits not less than two-thirds (2/3) of its patients with a primary diagnosis or suspected disease or condition directly related to the specific area or areas in which the Hospital conducts research. Patients admitted because of an emergent life-threatening condition who could not be safely transported to another Hospital will not be considered as patients for these purposes.

Child: In addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an "eligible foster child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship.

Chiropractic: Skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment s done by a Physician to remove nerve interference resulting from, or related to distortion, misalignment or subluxation of, or in, the vertebral column.

Claimant: Any Covered Person on whose behalf a claim is submitted for Plan benefits.

Contract Administrator/Claim Administrator/Third Party Administrator: A company that performs all functions reasonably related to the administration of one or more benefits of the Plan (e.g., processing of claims for payment) in accordance with the terms and conditions of the SPD and an administration agreement between the Contract Administrator and the Plan Sponsor.

The Contract Administrator is not a fiduciary of the Plan and does not exercise any discretionary authority with regard to the Plan. The Contract Administrator is not an insurer of Plan benefits, is not a fiduciary of the Plan, is not responsible for Plan financing and does not guarantee the availability of benefits hereunder.

Covered Expense/Eligible Expense: A Usual and Customary fee for a Reasonable, Medically Necessary service or supply, which are eligible for coverage under this Plan. Covered Expenses will be determined based upon all other Plan provisions. Covered Expense fees are never more than the amount paid to an In-Network Provider.

Covered Person: A Plan Participant, an eligible Dependent, and a Qualified Beneficiary (COBRA). See **Eligibility and Effective Dates** and **COBRA Continuation Coverage** sections for further information.

NOTE: In enrolling an individual as a Covered Person or in determining or making benefit payments to or on behalf of a Covered Person, the eligibility of the individual for state Medicaid benefits will not be taken into account.

Covered Provider: An in-network individual who is:

- licensed to perform certain health care services that are covered under the Plan and who is acting within the scope of his license; or
- in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association;

and who is, but not limited to, a/an:

- Advanced Clinical Practitioner (LMSW-ACP)

- Acupuncturist (CA)
- Audiologist
- Certified or Registered Nurse Midwife
- Certified Registered Nurse Anesthetist (CRNA)
- Chiropractor (DC)
- Dentist (DDS or DMD)
- Dietician
- Enterostomal therapist
- Licensed Clinical Psychologist (PhD or EdD)
- Licensed Clinical Social Worker (LCSW)*
- Licensed Practical Nurse (LPN)
- Licensed Professional Counselor (LPC)
- Licensed Vocational Nurse (LVN)
- Marriage and Family Therapists
- Nurse Practitioner
- Occupational Therapist (OTR)
- Optometrist (OD)
- Physical Therapist (PT or RPT)
- Physician - see definition of “Physician”
- Physician Assistant (PA)
- Podiatrist or Chiropodist (DPM, DSP, or DSC)
- Psychiatrist (MD)
- Registered Nurse (RN)
- Respiratory Therapist
- Speech Pathologist

A “Covered Provider” will also include the following when appropriately-licensed and providing services that are covered hereunder:

- Any practitioner of the healing arts who is licensed and regulated by a state or federal agency, is providing services or supplies that are covered hereunder, and is acting within the scope of his license;
- facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, Birthing Centers, clinics;
- licensed Outpatient mental health facilities;
- freestanding public health facilities;
- hemodialysis and Outpatient clinics under the direction of a Physician (MD);
- enuresis control centers;
- home infusion therapy providers;
- durable medical equipment providers;
- prosthetists and prosthetist-orthotists;
- portable X-ray companies;
- independent laboratories and lab technicians;
- diagnostic imaging facilities;
- blood banks;

- speech and hearing centers; and
- ambulance companies.

NOTE: A Covered Provider does not include: (1) an eligible Plan Participant treating himself or any relative or person who resides in the eligible Plan Participant's household - see "Relative or Resident Care" in the list of **General Exclusions**, or (2) any Physician, nurse or other provider who is an Employee of a Hospital or other Covered Provider facility and who is paid by the facility for his services.

Custodial Care: Care or confinement provided primarily for the maintenance of the eligible Plan Participant, essentially designed to assist the eligible Plan Participant, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting out of bed, supervision over medication which can normally be self-administered and all domestic activities.

Deductible: The amount of covered medical expenses which must be paid by an eligible Plan Participant each Calendar Year before benefits are payable under this Plan. A separate Deductible applies to a Covered Employee and each of the Employee's Dependents, subject to the family Deductible limit. Copayments are not included.

Dependent: See **Eligibility and Effective Dates** section.

Diagnostic Service: Covered medical services when a test or procedure is performed on the order of a Physician or other professional Provider because of specific symptoms, in order to identify a particular condition, Disease, Illness or Injury.

Disability: Any Illness or Injury resulting from the same cause or related causes, including complications. Unrelated Illnesses that are being treated concurrently by one Physician shall be considered one Disability. The time period for a Disability shall be: (1) for an active Employee a Disability shall begin on the day the condition is first diagnosed or treated, or the Accident occurs, and shall end when the Employee returns to work for one full day, or remains treatment free for six consecutive months; (2) for a Dependent or eligible Retiree, a Disability will begin on the day the condition is first diagnosed or treated, or the Accident occurs, and shall end when the person remains treatment free for six consecutive months.

Disease: Any alternation of the body or any of its organs or parts that interrupts or disturbs the performance of vital functions thereby causing or threatening pain, weakness or dysfunction. A Disease can exist with or without an eligible Plan Participant's awareness of it and can be of known or unknown cause.

Durable Medical Equipment: Equipment prescribed by the attending Physician which is Medical Necessary; is primarily used to serve a medical purpose; is designed for prolonged use; and serves a specific therapeutic purpose in the treatment of an Injury or Illness.

Effective Date: When applied to a person's coverage under the Plan, means the first day of the person's coverage. The person's Effective Date may or may not be the same as the person's Enrollment Date (as "enrollment date" is defined by the Plan).

Eligible Medical Benefits: For purposes of this Plan, Eligible Medical Benefits or medical expenses, care, treatment, prescriptions or supplies means services and supplies specifically described in this SPD, unless otherwise required by federal law.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn Child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part. Emergency Room visits will have a broader definition for those states which allow denial of coverage based on diagnosis;

Emergency Medical Transportation: Ambulance services for an Emergency Medical Condition.

Emergency Room Care: Emergency services you get in an emergency room.

Emergency Services: With respect to an Emergency Medical Condition:

a) a medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Employee: An individual who works full time or part time for an Employer and based upon the number of hours worked may be eligible to participate in the Plan. An individual who does not meet the eligibility requirements in the Plan shall not be eligible to participate in the Plan under any circumstances.

Employer(s): The Employer or Employers participating in these Plan benefits as reflected in the General Plan Information section. The Plan and the Employer or Employers are distinct legal entities (i.e., an Employer is completely separate from the Plan).

ERISA: The Employee Retirement Income Security Act of 1974, as amended.

Excluded Services: Health care services this Plan doesn't pay for or cover.

Experimental and/or Investigational (Experimental) - Services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

a) do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or

b) are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A drug, device, or medical treatment or procedure is Experimental:

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

b) if reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:

- maximum tolerated dose;
- toxicity;
- safety;
- efficacy; and
- efficacy as compared with the standard means of treatment or diagnosis; or

c) if reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies are necessary to determine its:

- maximum tolerated dose;
- toxicity;

- safety;
- efficacy; and
- efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

- only published reports and articles in the authoritative medical and scientific literature;

- the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or

- the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

The Plan Sponsor and Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

Fiduciary: An entity having binding power to make decisions regarding Plan policies, interpretations, practices or procedures. A Fiduciary will thus include, but not be limited to, the Plan Administrator, officers and directors of the Plan Sponsor, investment committee members and Plan trustees, if any.

Formulary: A list of prescription medications compiled by the third party payer of safe, effective therapeutic Drugs specifically covered by this Plan.

Generic Drug: A prescription Drug that is FDA approved; is a chemically identical version of a Brand-name medication.

Genetic Information: Information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

GINA: The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care: Certain services and supplies for part time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part time or intermittent home health aide services provided through a Home Health Care Agency. Part of a formal treatment plan certified by the attending Physician, reviewed at least every thirty (30) days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient. This does not include general housekeeping services; physical, occupational and speech therapy; medical supplies; and laboratory services on behalf of the Hospital.

Home Health Care Agency: An agency or organization that:

a) is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services;

b) has policies established by a professional group associated with the agency or organization that includes at least one registered nurse (RN) to govern the services provided;

c) provides for full-time supervision of its services by a Physician or by a registered nurse;

d) maintains a complete medical record on each patient; and

e) has a full-time administrator.

In rural areas where there are no agencies that meet the above requirements or areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.

Hospice or Hospice Agency: An entity providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for eligible Plan Participants suffering from a condition that has a terminal prognosis of no more than six (6) months. A Hospice must have an interdisciplinary group of personnel that includes at least one Physician and one registered nurse, and 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.

Hospital: An institution which:

a) is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Hospitals;

b) complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

c) is primarily engaged in providing medical treatment to sick and injured persons as registered bed patients and maintains permanent facilities for five or more such patients;

d) is operated under the supervision of a staff of Physicians;

e) continuously provides twenty-four (24)-hour-a-day nursing service by registered nurses;

f) maintains a daily medical record for each patient;

g) maintains facilities for diagnosis of Injury or disease;

h) maintains permanent facilities for major surgical operations on its premises; and

i) is not, other than incidentally: (1) a place of rest, for custodial care, for the aged, or for the care of senile persons, (2) a nursing home, (3) a hotel, or (4) a school or similar institution.

For treatment of mental health conditions or substance abuse, a “Hospital” will also include a facility that is appropriately licensed to provide such specialty care in the area in which it is located and that is operating within the scope of that license.

Hospital Confinement: The confinement for any one accident, or all illnesses, which are being treated at the same time, in a hospital as a regular bed patient. If a claim is for an active employee who returns to work between confinements or goes 6 consecutive months without treatment for that cause, each hospitalization will be considered a new confinement. For dependents and retired employees, successive hospitalization for the same cause will be considered one confinement, unless the patient goes 6 consecutive months without treatment for that cause.

Hospital In-patient Confinement: The term “Hospital In-Patient Confinement” includes:

a. Confinement as a registered bed patient for 24 hours or more.

b. Confinement for out-patient surgery.

c. Emergency care in the out-patient department of a hospital within 48 hours of an accidental injury.

Hospital Miscellaneous Services and Supplies: The Reasonable and Customary amounts charged by the Hospital for necessary services, medicines or supplies for diagnosis or treatment of an injury and illness (not to include services, drugs or supplies which are dispensed but not used in the Hospital) during a qualified Hospital In-patient Confinement.

Illness: A bodily disorder, disease, physical Illness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Incurred: That a covered expense is incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure, which includes several steps, or phases of treatment, covered expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, covered expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

Injury: An accidental physical Injury to the body caused by unexpected external means.

Inpatient: A person physically occupying a room and being charged for room and board in a facility (e.g., Hospital, or Skilled Nursing Facility) that is covered by the Plan and to which the person has been assigned on a twenty-four (24)-hour-a-day basis without being issued passes to leave the premises. After twenty-three (23) observation hours, a confinement will be considered an Inpatient confinement.

Intensive Care Unit (ICU), Coronary Care Unit (CCU), Burn Unit, or Intermediate Care Unit: A Hospital area or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician, that provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis and that is separated from the rest of the Hospital's facilities.

Licensed Technician or Clinic: The term "Technician" or "Clinic" shall mean a Provider who is licensed to perform or dispense:

a) Diagnostic X-rays and/or laboratory tests for diagnosis of a sickness or treatment of an injury; or

b) X-ray, cobalt or chemotherapy, blood transfusions, oxygen, dressings and surgical supplies.

Life-threatening Illness or Injury: "Life threatening," is either or both of the following: (a) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; (ii) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Medical or Surgical Supply House: The term "Medical or Surgical Supply House" shall mean a Provider licensed to sell or rent oxygen equipment, wheelchairs, crutches or other durable therapeutic equipment; or sell certain non-rentable medical equipment and post-surgical supplies which are not obtainable in a regular drug or department store and are usable only for the medical care of the patient. Payment of rental fees shall not exceed the actual cost of equipment.

Additional supply outlets covered under these terms include a provider of an initial prosthesis for:

a) Replacement of a natural part of the body removed while the patient was eligible under the Plan;

b) Needed to correct a congenital deformity of a child who was eligible under the Plan at birth;

c) Repair of such a prosthetic device.

Medically Necessary: "Medical Care Necessity", "Medically Necessary", "Medical Necessity" and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to an eligible Plan Participant for the purposes of evaluation, diagnosis or treatment of that eligible Plan Participant's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the eligible Plan Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the eligible Plan Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the eligible Plan Participant's Sickness or Injury without adversely affecting the eligible Plan Participant's medical condition.

a) it must not be maintenance therapy or maintenance treatment;

b) its purpose must be to restore health;

c) it must not be primarily custodial in nature;

d) it must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare); and

e) the Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the eligible Plan Participant is receiving or the severity of the eligible Plan Participant's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Sponsor's own medical advisors. The Plan Sponsor has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medical Record Review: The process by which the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Sponsor may determine the Maximum Allowable Charge according to the medical record review and audit results.

Medicare: Health Insurance for the Aged and Disabled as established by Title I of Public Law 89-98 including parts A, B & D and Title XVIII of the Social Security Act, and as amended from time to time.

Minimum Essential Coverage: Includes, at a minimum, all of the following statutory categories:

- Employer-sponsored coverage (including COBRA coverage and retiree coverage)
- Coverage purchased in the individual market
- Medicare Part A coverage
- Medicaid coverage
- Children's Health Insurance Program (CHIP) coverage
- Certain types of Veterans health coverage
- TRICARE

Non-Occupational Accidental Bodily Injury: The term "Non-occupational Accidental Bodily Injury" shall mean an accidental bodily injury resulting from an occurrence:

a) which does not arise out of or in the course of employment or any occupation for wage or profit, and

b) for which the individual is not entitled to benefits under any Workers' Compensation Law or similar legislation.

Non-Occupational Sickness: The term "Non-occupational sickness" and "Non-occupational illness" are interchangeable and shall mean a sickness or disease for which the individual is not entitled to benefits under any Workers' Compensation law or similar legislation, and which does not arise out of or in the course of any occupation for wages or profit.

Orthognathic Condition: A skeletal mismatch of the jaw (such as when one jaw is too large or too small, too far forward or too far back). An orthognathic condition may cause overbite, under bite, or open bite.

Orthotic Device: Any rigid or semi-rigid supportive devices that restrict or eliminates motion of a weak or diseased part of the body; to support, align, prevent or correct deformities, or to improve the function of movable parts f the body. Orthotic devices include but are not limited to Medically Necessary braces, back or special surgical corsets, splints for extremities and trusses when prescribed by a Physician, Podiatrist or Physical Therapist.

Outpatient: Services rendered on other than an Inpatient basis at a Hospital or at a covered non-Hospital facility.

Outpatient Alcohol/Drug Treatment Facility: An institution that:

a) provides a program for the diagnosis, evaluation and effective treatment of alcoholism, and/or drug use or abuse;

b) provides detoxification services needed with its effective treatment program;

c) provides infirmary level medical services or arranges 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 (RN);

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; or

g) meets licensing standards.

Outpatient Hospital: Any services performed or supplies dispensed in a Hospital out-patient department, emergency room or clinic under conditions which do not meet the Plan definition of "Hospital In-patient Confinement". This term shall include treatment of any injury due to a covered accident more than 48 hours after the accident, or non-surgical treatment of any covered illness.

Palliative Care: Treatment designed to alleviate symptoms without curing the condition.

Partial Hospitalization: An Outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than twenty-four (24) hours, but more than four hours a day and no charge is made for room and board.

Pharmacy: A licensed establishment where covered Prescription Drugs are filled and dispensed by a Pharmacist licensed under the laws of the state where he or she practices.

Physician: A Doctor of Medicine, (MD), or Doctor of Osteopathy, (DO), who is licensed to practice medicine or osteopathy where the care is provided.

NOTE: The term "Physician" will **not** include the Covered Person, or interns, residents, fellows or others enrolled in a graduate medical education program.

Pregnancy: The state of a female after conception and until termination of the gestation. See "Pregnancy Care" in the list of **Eligible Medical Expenses** for further information.

Prescription Drug: Any of the following: a Food and Drug Administration-approved Drug or medicine which under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such Drug must be Medically Necessary in the treatment of an Illness or Injury.

Plan: The plan of employee welfare benefits provided by the Plan Sponsor. The name of the Plan is shown in the General Plan Information section. The Plan and the Employer or Employers are distinct legal entities (i.e., an Employer is completely separate from the Plan).

Plan Year: The period commencing on October 1 and continuing through the following September 30, unless otherwise terminated by the Plan Sponsor. See **Miscellaneous Provisions** and **Termination of the Plan**.

Preventive Care: Specific preventive care services.

This Plan intends to comply with the Patient Protection and Affordable Care Act's (PPACA) by offering In-Network coverage for certain preventive services without cost-sharing. To comply with PPACA, and in accordance with its recommendations and guidelines, the Plan will provide In-Network coverage without cost sharing for:

- evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
- recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
- comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
- comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Prior to Effective Date or After Termination Date: Dates occurring before an eligible Plan Participant gains eligibility from the Plan, or dates occurring after an eligible Plan Participant loses eligibility from the Plan, as well as charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

Privacy Standards: The standards for privacy of individually identifiable health information, as enacted pursuant to HIPAA.

QMCSO - A Qualified Medical Child Support Order in accordance with applicable law.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Center: A facility that is designed to provide therapeutic and restorative services to sick or injured persons and that:

a) carries out its stated purpose under all relevant state and local laws;

b) is accredited for its stated purpose by either the JCAHO or the Commission on Accreditation for Rehabilitation Facilities; or

c) is approved for its stated purpose by Medicare.

Residential Treatment Facility: A state-licensed facility and community-based facility that is not a Hospital, but that provides residential care for persons with serious and persistent mental health conditions or substance abuse disorders. The facility must be operated twenty-four (24)-hours-per day to provide psychiatric and/or substance abuse and dependency treatment to its resident patients.

Security Standards: The final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

Semi-Private Room Charge: For the purpose of administering benefits, the term "Average Semi-Private Room Rates" shall mean the Reasonable and Customary charges made by the hospital for their average or most common Semi-Private room accommodations.

Sickness: Bodily Illness or disease (including covered mental health conditions and covered substance use disorders), congenital abnormalities, birth defects and premature birth. A condition must be diagnosed by a Physician or other appropriate Covered Provider in order to be considered a Sickness hereunder.

Skilled Nursing Facility: An institution that:

a) is duly licensed as a convalescent hospital, extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with the governing laws and regulations;

b) is primarily engaged in providing accommodations and skilled nursing care twenty-four (24)-hours-a-day for convalescing persons;

c) is under the full-time supervision of a Physician or a registered nurse;

d) admits patients only upon the recommendation of a Physician, maintains complete medical records, and has available at all times the services of a Physician;

e) has established methods and procedures for the dispensing and administering of drugs;

f) has an effective utilization review plan;

g) is approved and licensed by Medicare;

h) has a written transfer agreement in effect with one or more Hospitals; and

i) is not, other than incidentally, a nursing home, a hotel, a school or a similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

Specialist: A Physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a Provider who has more training in a specific area of health care.

Substance Use Disorder: Any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The DSM-IV definition is applied as follows:

- a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve (12)-month period:
  a. recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);

  b. recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);

  c. recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); or

  d. continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights); and

  e. the symptoms have never met the criteria for Substance Dependence for this class of substance.

Substance Use Disorder Treatment Center: An in-network Institution which provides a program for the treatment of Substance Use Disorder by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

a) affiliated with a Hospital under a contractual agreement with an established system for patient referral;

b) accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or

c) licensed, certified or approved as an alcohol or Substance Use Disorder treatment program or center by a State agency having legal authority to do so.

Substance Dependence: Substance use history which includes the following: (1) substance use disorder (see above); (2) continuation of use despite related problems; (3) development of tolerance (more of the drug is needed to achieve the same effect); and (4) withdrawal symptoms.

Summary Plan Description (SPD): This document, which describes the Plan and the rights and responsibilities of the Plan Sponsor and Plan Administrator with regard to the Plan, including any amendments.

Surgery or Surgical Procedure: Any of the following:

a) the incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;

b) the manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;

c) the removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;

d) the induction of artificial pneumothorax and injection of sclerosing solutions;

e) arthodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;

f) obstetrical delivery and dilation and curettage; or

g) biopsy.

Total Disability: The term "Total Disability" shall mean:

- For an Employee - a Disability which the attending Physician certifies as keeping the Employee from engaging in any gainful employment for wages or profit, for which the Employee is reasonably qualified by training and education.
- For a Dependent or Retiree - a Disability which the attending Physician certifies as keeping the person from engaging in the normal activities of a person the same age and sex.

Urgent Care Facility: An in-network facility that is engaged primarily in providing minor emergency and episodic medical care and that has:

- a board-certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance at all times; and
- X-ray and laboratory equipment and a life support system.

An Urgent Care Facility may include a clinic located at, operated in conjunction with, or that is part of a regular Hospital.

USERRA: The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Usual, Customary and Reasonable ("UCR"): Covered expenses which are identified by the Plan Sponsor, Usual and Customary charges are determined and established by the Plan Sponsor using Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

In the event that Medicare cost to charge ratios, AWP and/or MRP are unavailable, the Plan Sponsor may take into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with

similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term “Usual and Customary” does not necessarily mean the actual charge made nor the specific service or supply furnished to an eligible Plan Participant by a Provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Sponsor will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Reasonable and/or Reasonableness: In the Plan Administrator’s discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider. Determination that fee(s) or services are reasonable will be made by the Plan Sponsor, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Sponsor retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Sponsor. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed “reasonably preventable” through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

MISCELLANEOUS PROVISIONS

Administration

The Plan benefits described herein are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator. The Contract Administrator is not an insurance company.

Amendment or Termination of the Plan

Since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right, without the consent of any Covered Person and subject to the requirements of the Affordable Care Act, to:

- reduce, modify or terminate health care benefits hereunder, if any;
- alter or postpone the method of payment of any benefit;
- amend any provision of these administrative provisions;
- make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code; and
- terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest a Plan Participant of a right to those Plan benefits to which he has become entitled.

NOTE: Any modification, amendment or termination action will be done by written amendment that is signed by at least one Fiduciary of the Plan. Plan Participants will be provided with notice of the change within the time allowed by federal law.

Anticipation, Alienation, Sale or Transfer

Except for assignments to providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Plan Participant, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Clerical Error

Clerical error will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Collective Bargaining Agreements

Any collective bargaining agreements pursuant to which benefits under This Plan are established or maintained are available for inspection in the offices of the Plan Sponsor.

Contractual Arrangements

Contractual arrangements entered into by the Plan are intended to be for the exclusive benefit of the Plan and its Participants and beneficiaries. If the Plan Administrator, in its capacity as a fiduciary of the Plan, determines, in its sole discretion, that any contractual arrangement is not in the best interest of the Plan or violates applicable laws, the Plan Administrator shall provide benefits in accordance with its fiduciary duties regardless of any contractual arrangement to the contrary.

Contractual Limitations Period

A Plan Participant must file any action arising directly or indirectly from Your participation in this Plan no later than fifteen (15) months after the action has accrued. In the context of a claim for benefits, this is defined as the date a claim is paid or denied. By enrolling in this Plan the Plan Participant agree to waive any statute

of limitations to the contrary that might extend the right to file any action arising directly or indirectly from Your participation in the Plan. This Contractual Limitations Period applies to all enrollees, beneficiaries, and assignees and runs concurrently with the Plan's underlying administrative provisions.

Any action arising directly or indirectly from Your participation in the Plan must be filed in accordance with the Contractual Limitations Period above and shall be filed in the courts located in the city of Torrance, County of Los Angeles, State of California.

Discrepancies

In the event that there may be a discrepancy between any separate materials and this SPD, this SPD will prevail.

Discretionary Authority

The Plan Administrator has discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Exemption of State Law

Unless specifically required by Federal law, the Plan is exempt from compliance with any State's laws. Any provision, limitation, or terminology that can be interpreted as State law is a voluntary use by the Plan and shall not be construed as compliance or mandated by any State.

Fiduciary Responsibility & Authority

Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Plan Participants and their beneficiaries and for the exclusive purpose of providing benefits to the Plan Participants and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan Sponsor and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

Force Majeure

Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

Gender and Number

Except when otherwise indicated by the context, any masculine terminology will include the feminine (and vice-versa) and any term in the singular will include the plural (and vice-versa).

Illegality of Particular Provision

The illegality of any particular provision of the SPD will not affect the other provisions and will be construed in all respects as if such invalid provision were omitted.

Indemnification

To the extent permitted by law, the Employer's Plan Participants and their eligible Dependents, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Loss of Benefits

To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Covered Person might otherwise reasonably expect the Plan to provide based on the description of benefits:

- An Employee's cessation of active service for the Employer;
- A Covered Person's failure to pay his share of the cost of coverage, if any, in a timely manner;
- A dependent ceases to meet the Plan's eligibility requirements (e.g., a Child reaches a maximum age limit or a spouse divorces);
- An Employee or Covered Person fails to follow open enrollment requirements for enrolling in health benefits for an upcoming Plan Year;
- A Covered Person is injured and expenses for treatment may be paid by or recovered from a third party; or
- a claim for benefits is not filed within the time limits of the Plan.

Material Modification

In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Covered Persons and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days.

"Material modifications" are those which would be construed by the average Covered Person as being "important" reductions in coverage and generally would include any Plan modification or change that: (1) eliminates or reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations, (2) increases contributions, deductibles, coinsurance, copays, or other amounts to be paid by a Covered Person, or (3) establishes new conditions or requirements (i.e., preauthorization requirements) to obtaining services or benefits under the Plan.

Plan Participants must be furnished a Notice of Modification reflecting the change not later than 60 days prior to the effective date of the change, or 30 days before the Plan Year anniversary date, whichever is earlier, if such change is a benefit required to be detailed in the Summary of Benefits and Coverage (SBC).

Minimum Value Plan

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This Plan does meet the minimum value standard for the benefits it provides. This means that individuals may be eligible for a premium tax credit should he or she also seek health coverage from Covered California, the state's health insurance marketplace.

Misstatement / Misrepresentation

If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person

is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual in an enrollment form or claims filing, his eligibility, benefits or both, will be adjusted to reflect his true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

Misuse of Identification Card

If a Plan Participant or covered Dependent permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give the Plan Participant written notice that his (and his eligible Dependent's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

Non-Discrimination Due to Health Status

An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

- a medical condition (whether physical or mental and including conditions arising out of acts of domestic violence);
- claims experience;
- receipt of health care;
- medical history;
- evidence of insurability;
- disability; or
- genetic information.

Physical Examination

The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

Reimbursements

Plan's Right to Reimburse Another Party - Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Payment in Error - When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Plan Participant, Claimant or any other persons, insurance companies or other payees, and the Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Claimant, then the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Plan Participant or any of his Dependents,.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care

or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Plan Participant then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Plan Participant or any of his Dependents.

Rights Against the Plan Sponsor or Employer

Neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Employees will do nothing to prejudice such rights of the Plans and further they agree to do all acts necessary to preserve and take advantage of such rights. If payment has been made by the Plan in such instances and if the adverse party reimburses the Claimant directly, the Plan will have the right to recover such payment from a Claimant.

Termination for Fraud or Misrepresentation

An individual's coverage or eligibility for coverage will be terminated retroactive to the day (when permitted by law) and the Plan Administrator will retroactively rescind the benefits and/or coverage under the Plan, upon 30 days written notice to the Claimant, if:

- The Claimant or representative submit a claim or have a claim submitted by a Provider on their behalf that contains false or fraudulent information under state or federal laws;
- A civil or criminal court finds that the Claimant or representative has submitted claims that contained false or fraudulent information under state or federal laws;
- The Plan Participant provided false information about the Eligibility status of a Dependent;
- The Claimant performs an act, practice or omission that constitutes fraud or the Claimant makes an intentional misrepresentation of material fact, as determined by the Plan Administrator, Plan Sponsor (when not the Plan Administrator), or Third Party Administrator, relating to the terms of the Plan.

Substitution

Employees will do nothing to prejudice such rights of the Plan Sponsor and further they agree to do all acts necessary to preserve and take advantage of such rights. If payment has been made by the Plan in such instances and if the adverse party reimburses the Employee directly, the Plan will have the right to recover such payment from an Employee.

Territorial Limitations

Any benefits provided by the Plan are subject to reduction if services are rendered or expense is incurred outside the United States. The Plan Administrator reserves the right to determine benefits payable, if any, for all such services.

Assignment of Benefits to Providers located outside the United States will not be honored unless approved by the Plan in advance of the date of services.

Titles or Headings

Where titles or headings precede explanatory text throughout this Summary Plan Description, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the SPD and will not affect the validity, construction or effect of the SPD provisions.

Word Usage

Whenever words are used in this document in the singular or masculine form, they shall, where appropriate, be construed so as to include the plural, feminine, or neuter form.

Workers' Compensation

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

HIPAA PRIVACY

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Covered Persons. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Covered Person's PHI, and inform him/her about:

- the Plan's disclosures and uses of PHI;
- the Covered Person's privacy rights with respect to his/her PHI;
- the Plan's duties with respect to his/her PHI;
- the eligible Covered Person's right to file a complaint with the Plan and with the Secretary of HHS; and
- the person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining authorization, only if the use or disclosure is:

- to carry out Payment of benefits;
- for Health Care Operations;
- for Treatment purposes; or
- if the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);
- ensure that any agents, including a subcontractor, 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 such PHI;
- establish safeguards for information, including security systems for data processing and storage;
- maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
- receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;
- not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;

- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);
- make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);
- make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);
- make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);
- report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
- train employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    - the following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

        Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

    - in the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Sponsor shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Sponsor will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Sponsor or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

Other Disclosures and Uses of PHI

Primary Uses and Disclosures of PHI

Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Covered Person's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.

Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Person's information.

Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Covered Person has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.

Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

- a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;
- report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities; and
- locate and notify persons of recalls of products they may be using; and (d) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by (5) above, when required or authorized by law, or with the Covered Person's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Covered Person that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.

Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.

Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Covered Person's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Covered Person of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.

Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Covered Person's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.

Decedents: The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law.

Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.

To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.

Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

Disclosures to Covered Persons: The Plan is required to disclose to a Covered Person most of the PHI in a Designated Record Set when the Covered Person requests access to this information. The Plan will disclose a Covered Person's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Covered Person's personal representative if it has a reasonable belief that the Covered Person has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Covered Person's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Covered Person.

Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Covered Person's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Rights of Individuals

The Covered Person has the following rights regarding PHI about him/her:

Request Restrictions: The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.

Right to Receive Confidential Communication: The Covered Person has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests.

Copy of this Notice: The Covered Person is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.

Accounting of Disclosures: The Covered Person has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Person is entitled to such an accounting for the six (6) years prior to his/her request, though not earlier than April 14, 2003. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Covered Person of the basis of the disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Privacy Compliance Coordinator.

Access: The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Compliance Coordinator. In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial.

Amendment: The Covered Person has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Covered Person's request in certain cases, including if it is not writing or if he/she does not provide a reason for the request.

Questions or Complaints

If the Covered Person wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Covered Person may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Covered Person with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Covered Person for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Compliance Coordinator Contact Information:

Kathy Kasai
Manager – Health & Welfare Benefits
Torrance Unified School District
(310) 972-6089

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

Standards For Security of Individually Identifiable Health Information ("Security Rule")

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions

"Electronic Protected Health Information" (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

"Security Incidents" is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
- ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
- ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate report to the Plan any security incident of which it becomes aware.
- report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

- notify the individual whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than sixty (60) calendar days after discovery of the breach.
- notify the media if the breach affected more than five-hundred (500) residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than sixty (60) calendar days after the date the breach was discovered.
- notify the HHS Secretary if the breach involves five-hundred (500) or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than five-hundred (500) individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within sixty (60) days after the end of each calendar year.
- when a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will

notify the Plan without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a breach so that the affected individuals may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

STATEMENT OF RIGHTS

Covered Persons are entitled to certain rights and protections under the Plan, and shall be entitled to:

Receive Information About His/Her Plan and Benefits

This includes the right to:

- examine, without charge, at the Plan Sponsor's office and at other specified locations such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements; and
- obtain, upon written request to the Plan Sponsor, copies of documents governing the operation of a Plan, including insurance contracts and collective bargaining agreements. The administrator may make a reasonable charge for the copies. Where permitted by law, these documents may be provided electronically.

Continue Group Health Plan Coverage

This includes the right to continue health care coverage for himself/herself, or dependents if there is a loss of coverage under a Plan as a result of a Qualifying Event. The Qualified Beneficiary may have to pay for such coverage. See the **COBRA Continuation Coverage** section for additional details about these rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Covered Persons, the Plan imposes duties upon the people who are responsible for the operation of the Plan (the fiduciaries). Fiduciaries have a duty to operate a Plan prudently and in the interest of Covered Persons. No one, including the Employer, may fire a Covered Person or discriminate against him/her to prevent him/her from obtaining a welfare benefit or exercising rights under the Plan.

Enforce His/Her Rights

If an individual's claim for a welfare benefit is denied in whole or in part, he/she must receive a written explanation of the reason for the denial. He/she has the right to have the Plan Sponsor review and reconsider his/her claim.

There are steps a Covered Person can take to enforce the above rights. For instance, if he/she requests materials from a Plan and does not receive them within thirty (30) days, he/she may file suit in a Federal court. In such a case, the court may require the Plan Sponsor to provide the materials.

If he/she has a claim for benefits which is denied or ignored, in whole or in part, he/she may file suit in a state or Federal court. In addition, if he/she disagrees with the Plan decision or lack thereof, concerning the qualified status of a medical child support order (QMCSO), he/she may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if he/she is discriminated against for asserting his/her rights, he/she may seek assistance from the U.S. Department of Labor, or he/she may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If he/she is successful, the court may order the person he/she has sued to pay these costs and fees. If he/she loses, the court may order him/her to pay these costs and fees, for example, if it finds his/her claim is frivolous.

Assistance With His/Her Questions

If a Covered Person has any questions about a Plan, he/she should contact the Plan Sponsor.

COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan include a continuation of coverage option, which is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent will prevail over this summary.

There may be other coverage options for the Employee and his or her dependents. The Covered Person will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, the Covered Person could be eligible for a new kind of tax credit that lowers his or her monthly premiums right away, and the Covered Person can see what your premium, deductibles, and out-of-pocket costs will be before making a decision to enroll. Being eligible for COBRA does not limit eligibility for coverage for a tax credit through the Marketplace. Additionally, the Covered Person may qualify for a special enrollment opportunity for another group health plan for which he or she is eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if enrollment is requested within 30 days.

Definitions

When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary - An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee or the covered Dependent spouse (as defined by the federal Defense of Marriage Act) or Child of a covered Employee.

Any child who is born to or placed for adoption with a Plan Participant during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverages the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Plan Participant's Qualifying Event date and resultant continuation coverage period also apply to the child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

Exception: An individual is not a Qualified Beneficiary if Your status as a covered employee is attributable to a period in which You were a nonresident alien who received no earned income from the Participating Employer that constituted income from sources within the United States. If You are not a Qualified Beneficiary, then Your spouse or dependent Child is not a Qualified Beneficiary by virtue of the relationship to You.

NOTE: A Registered Domestic Partner is not a Qualified Beneficiary and does not have independent COBRA election rights. An Unregistered Domestic Partner is not a Qualified Beneficiary and does not have independent COBRA rights.

Qualifying Event - Any of the following events that would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

- voluntary or involuntary termination of the Plan Participant's employment for any reason other than the Plan Participant's gross misconduct;
- reduction in a Plan Participant's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not the Plan Participant actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a Plan Participant is on FMLA unpaid leave, a Qualifying Event occurs at the time he or she fails to return to work at the expiration of the leave, even if the Plan Participant fails to pay his or her portion of the cost of Plan coverage during the FMLA leave;
- for a Plan Participant's covered Dependent child, Plan Participant's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been

completed with the Social Security Administration and the Plan Participant has been notified that his or her Medicare coverage is in effect;

- for a Plan Participant's covered Dependent child, the divorce or legal separation of the Plan Participant and spouse;
- for a Plan Participant's covered Dependent child, the death of the covered Plan Participant; or
- for a Plan Participant's child, the child's loss of Dependent status (i.e. a Dependent child reaching the maximum age limit).

Non-COBRA Beneficiary - An individual who is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

Notice Responsibilities

If the Qualifying Event is the employee's termination/reduction in hours, death, or Medicare entitlement, then the Plan Administrator (i.e, the employer) must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights, or the unavailability of COBRA rights, within forty-four (44) days of the event. The Plan Administrator has contracted with a Third Party Administrator to provide the notification to the Qualified Beneficiaries. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

If COBRA continuation coverage terminates early (e.g., group health coverage is terminated for dependents, a Qualified Beneficiary fails to pay a required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election), the Plan Administrator must provide the Qualified Beneficiary(ies) with notification of such early termination. Notice must include the reason for early termination, the date of termination and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with a Plan Participant during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred that permits him to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiaries reside at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

A Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is a Dependent child's ceasing to be eligible under the requirements of the Plan. A Qualified Beneficiary must notify the Plan Administrator of a qualifying event within 60 days after a child's ceasing to be covered as a dependent under the Plan. A Qualified Beneficiary is also responsible for other notifications. See the section entitled **COBRA Notification Procedures** (and the employer's "COBRA General Notice" or "Initial Notice") for further details and time limits imposed on such notifications. Upon receipt of a notice, the Plan Administrator must notify the Qualified Beneficiary(ies) of their continuation rights within fourteen (14) days.

Election and Election Period

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) Sixty (60) days after coverage ends due to a Qualifying Event, or (2) Sixty (60) days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary. Failure to make a COBRA election within the sixty (60) day period will result in the inability to elect COBRA continuation coverage. See NOTE.

If the COBRA election of a Plan Participant does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Contract Administrator.

Annual open enrollment rights that allow Non-COBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. If all former Qualified Beneficiaries do not elect COBRA during the initial election period then annual open enrollment is not available. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

NOTE: See the "Effect of the Trade Act" provision for information regarding a second sixty (60) day election period allowance.

Effective Date of Coverage

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

Level of Benefits

COBRA continuation coverage will be equivalent to coverage provided to similarly situated Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated Non-COBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan include a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to his deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

Cost of Continuation Coverage

The cost of COBRA continuation coverage is fixed in advance for a twelve (12) month determination period and will not exceed 102% of the Plan's full cost of coverage during the period for similarly situated Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost that is paid by the Employer for Non-COBRA Beneficiaries. Qualified Beneficiaries will be charged 150% of the full cost for the eleven (11) month disability extension period if the disabled person is among those extending coverage.

The initial "premium" (cost of coverage) payment must be made within forty-five (45) days after the date of the COBRA election by the Qualified Beneficiary. **If payment is not made within such time period, the COBRA election is null and void.** The initial premium payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a thirty (30) day grace period allowed for payment. Payment is considered to be made on the date it is sent to the Plan or Plan Sponsor.

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase during the Plan's twelve (12) month determination period if:

- the cost previously charged was less than the maximum permitted by law;
- the increase occurs due to a disability extension (i.e., the eleven (11) month disability extension) and does not exceed the maximum permitted by law which is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or
- the Qualified Beneficiary changes his coverage option(s), which results in a different coverage cost.

Timely payments that are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's' payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least thirty (30) days) to make full payment. A payment will be considered an "insignificant shortfall" if it is not greater than $50 or 10% of the required amount, whichever is less.

If contributions are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received within the month of coverage and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTE: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically-indigent or due to a certain disability. The Employer's personnel offices should be contacted for additional information.

See the "Effect of the Trade Act" provision for additional cost of coverage information.

Maximum Coverage Periods

The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

- if the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is eighteen (18) months after the Qualifying Event. With a disability extension (see "Disability Extension" information below), the eighteen (18) months is extended to twenty-nine (29) months;
- if the Qualifying Event occurs to a Dependent due to the Plan Participant's enrollment in the Medicare program before the Plan Participant experiences a Qualifying Event, the maximum coverage period for the Dependent is thirty-six (36) months from the date the Plan Participant is enrolled in Medicare;
- for any other Qualifying Event, the maximum coverage period ends thirty-six (36) months after the loss of coverage due to the Qualifying Event.
- If a Qualifying Event occurs that provides an eighteen (18) month or twenty-nine (29) month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to thirty-six (36) months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events.

Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than thirty-six (36) months after the date of the first Qualifying Event.

COBRA entitlement runs concurrently with continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) - USERRA does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

Disability Extension

An eleven (11) month disability extension (an extension from a maximum eighteen (18) months of COBRA continuation coverage to a maximum twenty-nine (29) months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the Qualifying Event or at any time during the first sixty (60) days of COBRA continuation coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date that falls within the allowable periods described. The notice must be provided within sixty (60) days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his or her family must notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the eleven (11) month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the twenty-nine (29) month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension himself.

Termination of Continuation Coverage

Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above),COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the Qualifying Event and ending on the earliest of the following dates:

- the last day of the applicable maximum coverage period - see "Maximum Coverage Periods" above;
- the date on which the Employer ceases to provide any group health plan to any Employee;
- the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any pre-existing condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary;
- the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his or her Medicare coverage is in effect;
- in the case of a Qualified Beneficiary entitled to a disability extension, the later of:
    - Twenty-nine (29) months after the date of the Qualifying Event, or the first day of the month that is more than thirty (30) days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
    - the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;
- the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than thirty (30) days delinquent in paying the applicable premium). The Plan is required

to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly situated Non-COBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

COBRA and Medicare

If You are eligible for – but don't enroll in – Medicare Part A or B when you are first eligible, you will have an 8-month special enrollment period to sign up for Medicare Part A and/or B beginning on the earlier of

The month after your employment ends; or

The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second.

Effect of the Trade Act

In response to Public Law 107-210, referred to as the Trade Act of 2002 ("TAA"), the Plan is deemed to be "Qualified Health Insurance" pursuant to TAA, the Plan provides COBRA continuation of coverage in the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, as amended.

Eligible Individuals

The Plan Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation ("PBGC"), pursuant to TAA as of or after November 4, 2002. The Plan Administrator shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement, federal income tax filings, etc. The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

Temporary Extension of COBRA Election Period

Definitions:

Non-electing TAA-Eligible Individual – A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA continuation coverage during the TAA-Related Election Period.

TAA-Eligible Individual – An eligible TAA recipient and an eligible alternative TAA recipient.

TAA-Related Election Period – with respect to a TAA-related loss of coverage, the sixty (60) day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual.

TAA-Related Loss of Coverage – means, with respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

In the case of an otherwise COBRA Qualified Beneficiary who is a Non-electing TAA-Eligible Individual, such individual may elect COBRA continuation of coverage during the TAA-Related Election Period, but only if such election is made not later than six (6) months after the date of the TAA-Related Loss of Coverage.

Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period, and shall not include any period prior to such individual's TAA-Related Election Period.

Applicable Cost of Coverage Payments

Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA-Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in IRS regulations 54.4980B-8, A-5(d), the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.

There may be other coverage options for the Plan Participants and his or her dependents. The Covered Person will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, the Covered Person could be eligible for a new kind of tax credit that lowers his or her monthly premiums right away, and the Covered Person can see what your premium, deductibles, and out-of-pocket costs will be before making a decision to enroll. Being eligible for COBRA does not limit eligibility for coverage for a tax credit through the Marketplace. Additionally, the Covered Person may qualify for a special enrollment opportunity for another group health plan for which he or she is eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if enrollment is requested within 30 days.

COBRA NOTIFICATION PROCEDURES

It is a Covered Person's responsibility to provide the following Notices as they relate to COBRA Continuation Coverage:

Notice of Divorce or Legal Separation. Notice of the occurrence of a Qualifying Event that is Your divorce or legal separation from Your spouse.

Notice of Child's Loss of Dependent Status. Notice of a Qualifying Event that is a child's loss of Dependent status under the Plan (e.g., a Dependent child reaching the maximum age limit).

Notice of a Second Qualifying Event. Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of eighteen (18) (or twenty-nine (29)) months.

Notice Regarding Disability. Notice that: (a) a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of eighteen (18) months has been determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of continuation coverage, or (b) a Qualified Beneficiary as described in "(a)" has subsequently been determined by the Social Security Administration to no longer be disabled.

Notice Regarding Address Change. It is important that the Plan Administrator be kept informed of the current addresses of all Covered Persons who are or may become Qualified Beneficiaries.

Notification must be made in accordance with the following procedures. Any individual who is either the Plan Participant, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the Plan Participant or Qualified Beneficiary may provide the Notice. Notice by one individual shall satisfy any responsibility to provide Notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Means of Notification & Delivery - Notification of the Qualifying Event must sent to the Plan Sponsor as identified on the Covered Person's COBRA Continuation Notice.

Content - Notification must include the nature of the Qualifying Event and must include any relevant documentation supporting the Qualifying Event (for example, a copy of the Divorce Decree, certified copy of the Birth Certificate, etc.).

Time Requirements for Notification - Should an event occur (as described in NOTICE RESPONSIBILITIES above), the Plan Participant, other Qualified Beneficiary, or a representative acting on behalf of any such person) must provide Notice to the designated recipient within a certain time frame.

In the case of a divorce, legal separation or a child losing dependent status, Notice must be delivered within sixty (60) days from the later of: (1) the date of the Qualifying Event, (2) the date health plan coverage is lost due to the event, or (3) the date the Qualified Beneficiary is notified of the obligation to provide Notice through the Summary Plan Description or the Plan Sponsor's General COBRA Notice. If Notice is not received within the sixty (60)-day period, COBRA Continuation Coverage will not be available, except in the case of a loss of coverage due to foreign competition where a second COBRA election period may be available – see "Effect of the Trade Act" in the **COBRA Continuation Coverage** section of the Plan's SPD.

If a Plan Participant or Qualified Beneficiary is determined to be disabled under the Social Security Act, Notice must be delivered within sixty (60) days from the later of: (1) the date of the determination, (2) the date of the Qualifying event, (3) the date coverage is lost as a result of the Qualifying Event, or (4) the date the covered Employee or Qualified Beneficiary is advised of the Notice obligation through the SPD or the Plan Sponsor's General COBRA Notice. Also, Notice must be provided within the eighteen (18)-month COBRA coverage period.

The Plan will not reject an incomplete Notice as long as the Notice identifies the Plan, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete Notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a Reasonable period of time following the request.

APPENDIX - FEDERALLY REQUIRED PREVENTIVE CARE SERVICES

When the following covered preventive care services are provided by an In-Network provider, a Covered Person will not have to a meet a deductible, pay a Copay or pay a percentage share of the cost. SERVICES OBTAINED FROM A OUT-OF-NETWORK PROVIDER ARE NOT COVERED BY THIS PLAN.

NOTE: The following list is subject to change periodically. Check the website references for the most up-to-date and more comprehensive information.

Your health plan's Preventive Care benefit will only cover these preventive services at a frequency recommended by the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics, based on your age and risk factors.

Benefits are paid at no cost sharing for all Covered Expenses provided by a Covered Provider for the following:

Preventive Services for Adults

Abdominal Aortic Aneurysm	one-time screening for men of specified ages who have ever smoked
Alcohol Misuse	screening and counseling
Aspirin	use for men and women age 50 to 59 years with a high cardiovascular risk
Blood Pressure	screening for all adults
Cholesterol	screening for adults of certain ages or at higher risk
Colorectal Cancer	screening for adults age 50 to 75
Depression	screening for adults
Type 2 Diabetes	screening for adults age 40 to 70 who are overweight or obese
Diet	counseling for adults at higher risk for chronic disease
Falls prevention	with exercise or physical therapy and vitamin D use for adults age 65 and over, living in a community setting
Hepatitis B	screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.
Hepatitis C	screening for adults at increased risk, and one-time screening for everyone born 1945-1965
HIV	screening for ages 15 to 65, and other ages at increased risk
Immunization	All immunizations subject to medical necessity, indications, contraindications and age requirements (special populations and situations may affect medical necessity, age and dose series). Please visit https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ for the most current information." • Diptheria. • Hepatitis A • Hepatitis B • Herpes Zoster (RZV)

Immunization	• Human Papillomavirus • Influenza (Flu Shot) • Measles • Meningococcal--Mumps • Pertussis • Pneumococcal • Rubella • Tetanus • Varicella
Lung Cancer	screening for adults ages 55-80 at high risk for lunch cancer because they're heavy smokers or have quit in the past 15 years
Obesity	screening and counseling for all adults
Sexually Transmitted Infection (STI)	prevention counseling for adults at higher risk
Statin Preventive	medication for adults ages 40-75 at high risk
Syphilis	screening for all adults at higher risk
Tobacco Use	screening for all adults and cessation interventions for tobacco users
Tuberculosis	screening for certain adults without symptoms at high risk

Preventive Services for Women, Including Pregnant Women

Anemia	screening on a routine basis
BRCA	screening for women at higher risk
Breast Cancer Mammography	screenings every 1 to 2 years for women over 40
Breast Cancer Chemoprevention	counseling for women at higher risk
Breastfeeding	comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women. Breast pump: coverage for a standard electric pump (non-hospital grade) while you are pregnant, or for the duration of breastfeeding, once every three years, or a manual breast pump while pregnant or for the duration of breastfeeding if you have not received an electric or manual breast pump in the last three years and another set of breast pump supplies if you get pregnant again before you are eligible for a new pump.
Cervical Cancer	Pap test (also called a Pap smear) every 3 years for women ages 21 to 65, and Human Papillomavirus (HPV) DNA test with the combination of a Pap smear every 5 years for women ages 30 to 65 who don't want a Pap smear every 3 years.
Chlamydia Infection	screening for younger women and other women at higher risk
Contraception	Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
Diabetes	screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes

Domestic and interpersonal violence	screening and counseling for all women
Folic Acid	supplements for women who may become pregnant
Gestational diabetes	screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
Gonorrhea	screening for all women at higher risk
Hepatitis B	screening for pregnant women at their first prenatal visit
Human Immunodeficiency Virus (HIV)	screening and counseling for sexually active women
Human Papillomavirus (HPV) DNA Test	high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
Maternal Depression	Screening for mothers of infants at 1, 2, 4, and 6-month visits
Osteoporosis	screening for women over age 60 depending on risk factors
Preeclampsia	prevention and screening for pregnant women with high blood pressure
Rh Incompatibility	screening for all pregnant women and follow-up testing for women at higher risk
Sexually Transmitted Infections (STI)	counseling for sexually active women
Syphilis	screening for all pregnant women or other women at increased risk
Tobacco Use	screening and interventions for all women, and expanded counseling for pregnant tobacco users
Urinary Incontinence	screening for women yearly
Well-woman visits	Well-woman visits to obtain recommended preventive services

Preventive Services for Children

Alcohol, Tobacco, and Drug Use	assessments for adolescents
Autism	screening for children at 18 and 24 months
Behavioral	assessments for children of all ages Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
Bilirubin Concentration	screening for newborns
Blood Pressure	screening for children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
Blood Screening	screening for newborns
Cervical Dysplasia	screening for sexually active females
Depression	screening for adolescents beginning routinely at age 12
Developmental	screening for children under age 3
Dyslipidemia	screening for all children once between ages 9 and 11 and once between ages 17 and 21, and for children at higher risk of lipid disorders Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

Fluoride Chemoprevention	supplements for children without fluoride in their water source
Fluoride Varnish	for all infants and children as soon as teeth are present
Gonorrhea	preventive medication for the eyes of all newborns
Hearing	screening for all newborns; and for children once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years
Height, Weight and Body Mass Index	measurements for children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
Hematocrit or Hemoglobin	screening for children
Hemoglobinopathies	or sickle cell screening for newborns
Hepatitis B	Screening for adolescents at high risk, including adolescents from countries with 2% or more Hepatitis B prevalence, and U.S.-born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence: 11-17 years
HIV	screening for adolescents
Hypothyroidism	screening for newborns
Immunization	All immunizations subject to medical necessity, indications, contraindications and age requirements (special populations and situations may affect medical necessity, age and dose series). Please visit https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ for the most current information". • Diphtheria, Tetanus, Pertussis (Whooping Cough) • Haemophilus influenzae type b • Hepatitis A • Hepatitis B • Human Papillomavirus • Inactivated Poliovirus • Influenza (Flu Shot) • Measles • Meningococcal • Pneumococcal • Rotavirus • Varicella (chickenpox)
Iron	supplements for children ages 6 to 12 months at risk for anemia
Lead	screening for children at risk of exposure
Medical History	for all children throughout development Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
Obesity	screening and counseling

Oral Health	risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
Phenylketonuria (PKU)	screening in newborns
Sexually Transmitted Infection (STI)	prevention counseling and screening for adolescents at higher risk
Tuberculin	testing for children at higher risk of tuberculosis Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
Vision	screening for all children

Important Details:

- The plan only provides these preventive services through a network provider. The plan may allow an eligible Plan Participant to receive these services from a Non-Network provider, but the eligible Plan Participant may have to pay all or part of the cost.
- A doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that the plan can require the eligible Plan Participant to pay some costs of the office visit if the preventive service is not the primary purpose of the visit, or if the doctor bills the claimant for the preventive service separately from the office visit.
- An eligible Plan Participant should ask his health care provider to help him understand which covered preventive services are right for him – based on his age, gender and health status.

Website References:

Covered preventive services: http://www.uspreventiveservicestaskforce.org/

Overview: https://www.healthcare.gov/preventive-care-benefits/

ADOPTION OF THE DOCUMENT

Adoption

The Plan Sponsor hereby adopts this document on the date shown below.

This document replaces any and all prior statements of the Plan benefits that are described herein and in that respect this document is adopted as the SPD which describes the benefits of the intended Plan. Any clerical error either adding, changing, reducing or eliminating benefits otherwise intended by this Plan, may or may not be construed as a Covered Expense and benefit payable under this Plan at the sole discretion of the Plan Administrator.

In the event of any conflict between this SPD and the legal document for the Plan, the legal document will prevail.

Purpose of the Plan

The purpose of the Plan is to provide certain benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents. The benefits provided by the Plan are as listed in the General Plan Information section.

Conformity with Law

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Participating Employers

Employers participating in this Plan are as stated in the section entitled General Plan Information. The Plan Sponsor may act for and on behalf of any and all of the Participating Employers in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor will be binding on all such Employers.

Acceptance of the Document

We, the Plan Sponsor, recognize that we have full responsibility for the contents of the SPD and its compliance with federal and state laws and regulations and that, while the Contract Administrator, its employees and/or subcontractors, may have assisted in the preparation of the document, we are responsible for the final content, text, meaning and compliance with applicable federal and state laws. We understand that this document is written to reflect the intention of the Plan Sponsor to offer the specific benefits described herein and the compliance of these benefits, terms, conditions, limitations and exclusions (in other words, the full content describing the Plan) with any state or federal law is not the responsibility of the Contract Administrator, its employees and/or subcontractors. We further certify that the document has been fully read, understood, and describes our intent with regard to our employee welfare plan.

The Plan Sponsor has caused this instrument to be executed, effective as of October 1, 2020

Torrance Unified School District

By: _____

Title: _____

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