PLAN DOCUMENT AND

SUMMARY PLAN DESCRIPTION

FOR

WA-NEE COMMUNITY SCHOOLS HEALTH CARE PLAN

Restated

December 1, 2018

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INTRODUCTION

This document is a description of the **Wa-Nee Community Schools Health Care Plan** (the "Plan"). No oral interpretations or representations can change this Plan. The Plan described is designed to protect Covered Persons against certain catastrophic health expenses. This booklet contains a summary in English of your rights and benefits under this health care plan. If you have difficulty understanding any part of this booklet, contact the Plan Administrator identified in the General Plan Information section of this booklet.

Nota: *Este libro contiene un sumario en Ingles de sus derechos y beneficios bajo este Plan de salud. Si usted tiene algún problema o no entiende cualquier parte de los beneficios por su lenguaje, o por cualquier razón, por favor de comunicarse con el Administrador del Plan identificado atrás de este libro.*

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy all of the eligibility requirements of the Plan.

The Plan Sponsor fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan, including benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, eligibility and the like. Failure to follow the eligibility or enrollment requirements of the Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, failure to establish Medical Necessity, failure to timely file a claim or lack of coverage. These provisions are explained in summary fashion in this Plan Document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses Incurred while this coverage is in force. No benefits are payable for expenses Incurred before coverage began or after coverage terminated, even if the expenses were Incurred as a result of an accident, Injury or disease that occurred, began or existed while coverage was in force.

If the Plan is terminated or amended or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges Incurred before termination, amendment or elimination.

This Plan Document summarizes the rights and benefits of Covered Persons and is divided into the following parts:

Eligibility, Funding, Effective Date, Termination Provisions – Explains eligibility for coverage under the Plan, funding of the Plan and when coverage takes effect and terminates.

Schedule of Benefits – Provides an outline of the Plan's reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions – Explains when the benefit applies and the types of charges covered.

Cost Management Services* – Explains the methods used to curb unnecessary and excessive charges.

**This part should be read carefully since each Covered Person is required to take action to assure that the maximum levels under the Plan are paid.*

Defined Terms – Defines those Plan terms that have a specific meaning.

Plan Exclusions – Shows what charges are not covered.

Claim Provisions – Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits – Shows the Plan payment order when a person is covered under more than one plan.

Subrogation, Third Party Recovery and Reimbursement – Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of Injuries sustained.

COBRA Continuation Options – Explains when a person's coverage under the Plan ceases and the continuation options which are available.

Privacy and Security Information – *THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.*

Note: *The Plan Administrator may condition enrollment into the Plan or eligibility for benefits on you providing authorization to disclose **Protected Health Information (PHI)** when the authorization is requested by the Plan prior to your enrollment in the Plan if (1) the authorization sought is for the Plan's eligibility or enrollment determinations relating to you or for the Plan's underwriting or risk rating determinations and (2) the authorization is not for use of disclosure of psychotherapy notes.*

PHI may be accessed by the Plan Administrator, privacy officer, or their designee, and business associates who perform administrative functions on behalf of the Plan, such as, but not limited to, benefit management, claim processing, utilization review, disease management programs, managed care programs, billing, data analysis, legal, actuarial, consulting, accounting or other related services. Business associates will safeguard this information in the same manner as the Plan Administrator.

The Standards for Privacy of Individually Identifiable Health Information ("Privacy Standards") protect medical records and other confidential health information that identifies (or could reasonably be used to identify) an individual, and relate to a past, present or future physical or mental condition of the individual or the provision of health care to an individual, or the payment for the provision of health care to the individual. This individually identifiable health information can be in any form (including electronic, written, or oral) that is created or received by a health plan (or other Covered Entity, as defined in the Privacy Standards) or employer.

1. **Disclosure of Summary Health Information to the Plan Sponsor**

   In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

   "Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

2. **Disclosure of Protected Health Information ("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:

   a) 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);

   b) 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;

   c) 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;

d) 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;

e) Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

f) 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);

g) 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);

h) 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);

i) 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

j) 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:

   (i) 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:

   Business Manager and staff member(s) designated by the Human Resources Manager.

   (ii) The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

   (iii) In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. 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.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

3. 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 disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

4. Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims 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.

5. Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

6. HIPAA Security Standards

The Plan shall comply with the HIPAA Security rules (45 C.F.R. parts 160, 162 and 164) as they apply to electronic protected health information. The Plan Administrator shall implement administrative, physical, and technical safeguards that reasonably protect the confidentiality, integrity, and availability of EPHI that is created, received, maintained or transmitted by or on behalf of the Plan. The Plan shall ensure that any independent contractor, agent or subcontractor with which the Plan enters into services agreements that involve EPHI shall implement reasonable and appropriate safeguards to protect such information. Any security incident (as defined in 45 CFR Section 164.304) relating to EPHI of which the Plan Administrator becomes aware shall be reported to the Plan and appropriate action shall be taken in conformance with applicable regulations.

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 that 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;

Right to Receive Notice of Privacy Practices: The Covered Person is entitled to receive a paper copy of the plan's Notice of Privacy Practices 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. 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, or to have a copy of your PHI transmitted directly to another designated person, contact the Privacy Compliance Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Covered Person and the recipient must be clearly identified. The Plan must respond to the Covered

Person’s request within thirty (30) days (in some cases, the Plan can request a thirty (30) day extension). 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 in writing or if he/she does not provide a reason for the request; and

Fundraising Contacts: The Covered Person has the right to opt out of fundraising contacts.

7. Security of Electronic Protected Health Information

The Plan will comply with the HIPAA Security Rule under the Health Information Technology for Economic and Clinical Health (HITECH) Act. The Plan will ensure that any independent contractor, agent or subcontractor with which the Plan enters into service agreements that involve EPHI will implement reasonable and appropriate safeguards to protect such information. Any security incident relating to EPHI of which the Plan Administrator becomes aware will be reported to the Plan and appropriate action will be taken in conformance with applicable regulations. The Notice and Reporting requirements of any breach will conform to subpart D, part 164 of title 45 Code of Federal Regulations. A "breach" is defined as the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of the PHI, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to keep the information. The phrase "compromises the security or privacy of the PHI" means the breach poses a significant risk of financial harm, harm to reputation, or other harm to the individual.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBLE CLASSES OF EMPLOYEES

The following classes of Employees are eligible to enroll in the Plan for coverage:

1. All Full-time, active employees who are reasonably expected to work at least 30 hours or more per week.
2. Bus Drivers: Minimum requirement to be considered eligible is a driver who drives two routes per day.
3. Administrators: Active, no hour requirement.
4. Retired Employees under age 65.
5. Active Employees enrolled prior to October 01, 2013 shall remain eligible regardless of the above eligibility requirements.
6. Temporary Employees who are reasonable expected to work 30 hours per week.

Note: *Eligible classes remain covered during breaks in the school year.*

If, based on the facts and circumstances at the employee's start date, it cannot be determined whether the employee is reasonably expected to work at least 30 hours per week, eligibility is determined as follows:

Newly Hired Variable Hour Employees The Employer will count the employee's hours based on an Initial Measurement Period (IMP) of 12 months starting on the first day of the month following the date of hire, followed by a 1 month Initial Administrative Period (IAP). If during the Initial Measurement Period (IMP) it is determined that the employee has satisfied the 30 hour per week threshold, coverage will be effective on the first of the month following the end of the Initial Administrative Period (IAP). (Example: A is hired on May 10, 2013, A's IMP will run from June 1, 2013 to May 31, 2014. A will be effective for coverage on July 1, 2014 and his coverage will continue until June 30, 2015, this is known as the Initial Stability Period (ISP) regardless of the number of hours A works from July 1, 2014 to June 30, 2015, the ISP.)

Current Variable Hour Employees The Employer will count the employee's hours based on a Standard Measurement Period (SMP) of 12 months starting on October 1st of each year. If during this Standard Measurement Period (SMP) it is determined that the employee has satisfied the 30 hour per week threshold, coverage will be effective on December 1st. (Example: B works an average of 30 hours per week during the SMP. B will be effective for coverage on December 1st and his coverage will continue until November 30th, this is known as the Standard Stability Period (SSP) regardless of the number of hours he works during the SSP.)

If it is determined that the employee has not satisfied the 30 hour per week threshold during the 12 month IMP or SMP, the employee will remain ineligible for coverage during the following 12 month stability period. Wa-Nee Community Schools declares the following:

Standard Measurement Period for ongoing employees: October 1 – September 30 (12 months)

Standard Administrative Period: October 1 – November 30 (61 days)

Standard Stability Period for ongoing employees: December 1 – November 30 (12 months)

ELIGIBLE CLASSES OF DEPENDENTS

A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a Child qualifies or continues to qualify as a Dependent.

A "Dependent" is any one of the following persons:

1. A covered Employee's Spouse and Children from birth to the limiting age of **26** years who reside in the United States. When the Child reaches the Plan's limiting age, coverage will end on the first day of the month following Child's birthday. The spouse and Children of a married covered Dependent are not eligible for Plan coverage.

   The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

   The term "Children" shall include natural Children, Children adopted prior to the age of 18 or Children placed with a covered Employee in anticipation of adoption. Stepchildren or Foster Children may also be included.

   Children for whom the Employee is required to provide coverage due to a valid Qualified Medical Child Support Order (QMCSO) will be enrolled in the Plan without regard to enrollment restrictions. If 'Dependent only' coverage is offered, the Child or Children may be added to the Plan independently of the Employee. If 'Dependent only' coverage is not offered, the Child or Children and the parent will be enrolled. A Covered Person may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

   If a covered Employee has been appointed Legal Guardian by a court with jurisdiction or has a court order awarding permanent custody of an unmarried Child or Children, these Children may be enrolled in the Plan as covered Dependents.

   The phrase "placed with a covered Employee for adoption" means the assumption and retention of a legal obligation for total or partial support of a Child by a covered Employee in anticipation of the Child's adoption. The Child's placement for adoption with the covered Employee terminates upon the termination of such legal obligation.

2. A covered Dependent Child who is Totally Disabled, incapable of self-sustaining full-time employment by reason of mental or physical handicap and primarily dependent upon the covered Employee for support and maintenance; unmarried and was continuously covered under a health plan when reaching the limiting age is eligible for Plan coverage. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the Child's Total Disability and dependency.

   After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

<u>These persons are excluded as Dependents</u>: other individuals living in the covered Employee's home, but who are not eligible under the terms of this Plan Document; the legally separated or divorced former Spouse of the Employee; any Dependent (including a spouse) who is on active duty in the military service of any country; foster children, or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change

in status, credit will be given for deductibles and all amounts applied to maximums to the extent it has already been met.

If both mother and father are Employees, their Children will be covered as Dependents of the mother or father, but not both.

If husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating Spouse and any eligible and enrolled Dependents will immediately be transferred to the remaining Employee's coverage.

RETIREE COVERAGE

In accordance with Indiana Code 5-10-8-2.1, a Retired Employee:

a) Whose retirement date is after June 30, 1986;

b) Who will have reached upon retirement fifty-five (55) years of age but who will not be eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.;

c) Who will have completed twenty (20) years of creditable employment with a public employer, ten (10) years of which must have been completed immediately preceding retirement; and

d) Who will have completed upon retirement at least fifteen (15) years of participation in the retirement plan of which the Employee is a member.

Is entitled to participate in the health plan program if the Employee pays both the Employer's and the Employee's premiums for the coverage.

A Retired Employee's eligibility to continue coverage under this section ends when the Employee becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq., or when the employer terminates the health plan coverage A Retired Employee may elect to have the Employee's Spouse covered under the health plan at the time the Employee retires. A Spouse's subsequent eligibility to continue coverage under this section is not affected by the death of the Retired Employee, but ends when the Spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq., or when the Employer terminated the health plan coverage.

An Employee who is on a leave without pay is entitled to participate in any health plan program maintained by the Employer if the Employee pays both the Employer's and the Employee's premiums for the coverage.

ENROLLMENT

Employee Enrollment Requirements – An Employee must enroll for coverage by filling out and signing an enrollment application.

Dependent Enrollment Requirements – A Dependent must be enrolled for coverage on the Employee's enrollment application. Newly acquired Dependents must be enrolled within 31 days for the enrollment to be considered "timely"; otherwise the Dependent will be considered a Late Enrollee.

Dependent Enrollment Requirements for Newborn Children – A covered Employee is to provide the paperwork required by the Plan within 31 days (timely enrollment) of the newborn Child's birth in order for the Child to be enrolled and covered under the Plan..

Charges for covered services will be applied toward the Plan of the newborn Child. If the newborn Child is not enrolled in the Plan on a "timely" basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the Child is not timely enrolled within 31 days of birth, the Child will be considered a Late Enrollee.

Timely Or Late Enrollment

1. **Timely Enrollment** – The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for coverage initially.

2. **Late Enrollment** – An enrollment is "late" if it is not made on a "Timely Enrollment Basis". Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment (if applicable).

   The time between the dates a Late Enrollee becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

EFFECTIVE DATE

Effective Date of Employee Coverage – An Employee will be covered under this Plan as of the **first** day of the calendar month following the date that the Employee satisfied all of the following:

1. is in an eligible class for coverage;
2. the Active Employee requirement;
3. the enrollment requirements of the Plan; and
4. completes the Waiting Period of **first of the month following employment**.

Effective Date of Temporary Employee Coverage – A Temporary Employee will be covered under this Plan as of the **first** day of the calendar month following the date that Employee satisfied all of the following:

1. is in an eligible class for coverage;
2. the Active Employee requirement;
3. the enrollment requirements of the Plan; and
4. completes the Waiting Period of **60** consecutive days as an Active Employee.

A **"Waiting Period"** is the time between the first day of employment and the first date of coverage under the Plan.

Active Employee Requirement – An Employee must be an Active Employee for this coverage to take effect.

Effective Date of Dependent Coverage – Plan coverage for eligible Dependents who are enrolled at the same time as the Employee will be effective on the Employee's effective date, provided the Plan's timely enrollment requirements, including the Special Enrollment requirements where applicable, are met. Coverage for a Dependent acquired later will become effective as follows: a) in the case of marriage, on the date of the marriage; b) in the case of a Dependent's birth, as of the date of birth; c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

FUNDING

Cost Of The Plan

Wa-Nee Community Schools shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage may include a payroll deduction authorization or other authorized form. This authorization must be filled out, signed and returned with the enrollment application.

The Plan Sponsor sets the level of any Employee contributions and reserves the right to change the level of Employee contributions.

SPECIAL ENROLLMENT PERIODS

1. **Individuals Losing Their Coverage** – An Employee or Dependent who meet the Plan's eligibility requirements, but are not enrolled in this Plan, may enroll if each of the following conditions is met:

   a) An eligible Employee who experiences a family status change through marriage, birth, adoption, placement for adoption, or receives a judgment, decree, or order requiring coverage; or

   b) the Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual;

   c) if required by the Plan Administrator, the Employee stated in writing that at the time coverage was offered other health coverage was the reason for declining enrollment;

   d) the Employee or Dependent declined coverage under this Plan in favor of COBRA coverage and COBRA was exhausted, or the eligible person was not covered under COBRA and either the other coverage was terminated as a result of loss of eligibility (including as a result of legal separation, divorce, death, termination of employment, loss of Dependent Child status, reduction in the number of hours of employment, or a plan no longer offering benefits to a class of individuals that includes the eligible person), or due to termination of employer contributions;

   e) in the case of coverage offered through an HMO, or other arrangement, that does not provide benefits to individuals who no longer reside, live, or work in a service area, eligibility for coverage was lost because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual) and no other benefit package is available; or

   f) the individual incurs a claim under the other plan that equals or exceeds the other plan's lifetime limit on all benefits, and coverage under the other plan ends; **and**

   g) the Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage, loss of coverage, or termination of employer contributions, as described above. Where the Employee or Dependent requests enrollment under subparagraph f) above, the Employee or Dependent must request enrollment no later than 31 days after the earliest date a claim is denied by the other plan due to a lifetime limit on all benefits.

   If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums, required contributions or for cause (such as making a fraudulent claim) that individual does not have a Special Enrollment right.

   The Enrollment Date for anyone who enrolls under this Item 1 is the first date of coverage. Thus, the time between the dates a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

   The Eligible Employee or Dependent is not required to elect COBRA continuation under another employer's plan in order to become eligible for Special Enrollment under this Plan.

2. **Dependent Beneficiaries if:**

   a) the Employee is a Covered Person under this Plan (or has met the Waiting Period applicable to becoming a Covered Person under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

b) a person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption, then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a Child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption.

The coverage of the Dependent enrolled under this Item 2 will be effective:

(i) in the case of marriage, on the date of the marriage if a completed request for enrollment is received within 31 days of the date of the marriage;

(ii) in the case of a Dependent's birth, as of the date of birth;

(iii) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption;

(iv) in the case of loss of Dependent Child status under Item 1.(d) above, the first day of the first calendar month beginning after the date the Plan receives the request for Special Enrollment of the Dependent.

3. **Medicaid and Children's Health Insurance Special Enrollment 60-day Election Period** - An Employee and Dependent, or the Dependent of an enrolled Employee may elect to enroll in the Plan if the following occurs:

a) Medicaid or Children's Health Insurance Program (CHIP) terminates as a result of loss of eligibility and the Employee requests enrollment in the Plan within 60 days after the date of termination or loss of eligibility under the state program.

b) The Employee becomes eligible for a state premium assistance subsidy under Medicaid or CHIP and the Employee requests enrollment in the Plan within 60 days after the date of eligibility for the subsidy.

GENETIC INFORMATION NONDISCRIMINATION ACT ("GINA")

"GINA" prohibits group health plans, issuers of individual health care policies, and Employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a Disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include Dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting conditions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

TERMINATION PROVISIONS

TERMINATION OF COVERAGE

When coverage under this Plan stops, Covered Persons will receive a certificate that will show the period of coverage under this Plan. Please contact the Human Resources department of the Plan Administrator for further details. The Human Resources department's address and phone number appear in the General Plan Information section at the end of this Summary Plan Description.

***Note**: Coverage should continue during breaks between school years.*

When Employee Coverage Terminates – Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage; for a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the Plan section entitled "COBRA Continuation Options"):

1. the date the Plan is terminated;
2. the date the covered Employee's eligible class is eliminated;
3. the day the covered Employee ceases to be in one of the eligible classes. (This includes death or termination* of active employment of the covered Employee. See the "COBRA Continuation Options"); or

   **For a teacher completing the contract year, coverage is extended to October 1st of the following school year.*

4. the end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
5. immediately after an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff – A person may remain eligible for a limited time if active, full-time work ceases due to disability, or board approved leave of absence. This continuance will end as follows:

> Coverage shall not be continued for longer than the terms of the Board approved Leave of Absence as specified in Article 6.10 of the school contract, the leave policy for professional staff, and code 4430 of the educational policies of **Wa-Nee Community Schools** referencing the non-certified Family and Medical Leave of Absence policy.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued

person. Continued coverage is subject to the Employee's payment of the Employee contribution required under the Plan.

Continuation During Family and Medical Leave – Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the provisions of the Family and Medical Leave Act of 1993 ("FMLA") as amended and as promulgated in regulations issued by the Department of Labor. Requirements of the Act should be addressed with your Employer. The Employee on FMLA must pay the Employee contribution required under the Plan.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Eligible Employee and his or her covered Dependents if the Eligible Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when the coverage terminated. For example, other Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee – A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements, with the exception of an Employee returning to work directly from COBRA coverage under this Plan. The returning Employee who is covered under this Plan's COBRA Continuation Option does not have to satisfy the employment Waiting Period.

Employees on Military Leave – Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

1. The maximum period of coverage under a USERRA election shall be the lesser of:
   a) the 24-month period beginning on the date on which military leave begins; or
   b) the day after the date on which the person returning from military leave is required to apply for or return to a position or employment and fails to do so.
2. If Health Plan coverage is continued while on military leave, the Plan may require payment of up to 102% of the full cost of coverage under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
3. An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

Medicare Provision Applicable to Active Employees and Their Spouses Age 65 and Over – Active Employees (age 65 and over) may elect or reject coverage under this Plan. If coverage under this Plan is elected, the benefits of this Plan will be paid before any benefits provided for by Medicare. If coverage is rejected under this Plan, the Employee will not be eligible for benefits.

Medicare Provision Applicable to All Other Covered Persons Eligible for Medicare Benefits – To the extent required by federal regulations, this Plan will pay first before any Medicare benefits. Under some circumstances, Medicare is required to pay its benefits first. In these circumstances, benefits under this Plan would be calculated as secondary payor.

In determining Medicare benefits, this Plan will assume Employee has full coverage available from Medicare, whether or not enrolled.

When Dependent Coverage Terminates – A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled "COBRA Continuation Options"):

1. the date the Plan or Dependent coverage under the Plan is terminated;
2. the date that the Employee's coverage under the Plan terminates for any reason including death (see the COBRA Continuation Options);
3. the date a covered Spouse is no longer eligible for Plan coverage (see the COBRA Continuation Options);
4. on the first date that a Dependent Child ceases to be a Dependent as defined by the Plan (see the COBRA Continuation Options);
5. the end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

OPEN ENROLLMENT

OPEN ENROLLMENT

Every October 1st – October 31st, which is the Plan's annual open enrollment period, eligible Employees and their Dependent children will be able to enroll in the Plan. Late Enrollees who failed to enroll in the Plan when first eligible may also enroll.

An Eligible Spouse does not qualify for the Plan’s annual open enrollment period. Spouses who fail to elect coverage when they first become eligible will not be offered another opportunity to enroll unless they qualify for a Special Enrollment event.

Currently enrolled employees who wish to change between Plan coverage options may do so during the open enrollment period. There is no Waiting Period for a change in Plan coverage options.

Enrollment elections made during the open enrollment period will become effective December 1st.

Newly-eligible Employees and Covered Persons will receive detailed information regarding open enrollment from their Employer.

Covered Persons who fail to make an election during the annual open enrollment period will automatically retain their present coverage. Newly eligible Employees who fail to elect coverage during the open enrollment period may not enter the Plan during the Plan Year unless they have a Special Enrollment event.

SCHEDULE OF BENEFITS

Verification of Eligibility: Please refer to the number on your ID card. Call this number to verify eligibility for Plan benefits **before** the charge is Incurred.

Listing of Network Providers: Please refer to the PPO number on your ID card, or contact the Plan Administrator for a listing at no charge.

MEDICAL BENEFITS

All benefits described in this schedule are subject to the provisions, exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Reasonable and Customary Charges; and that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the "Defined Terms" section of this Plan Document. If additional information is required, contact the Plan Administrator and it will be provided to you at no cost.

***Note*: The following services must be pre-certified, or reimbursement from the Plan may be reduced by $500.**

INPATIENT HOSPITALIZATIONS*

**Please see the "Cost Management" section in this booklet for details.*

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

The Plan contains a Network Preferred Provider Organization (PPO).

This Plan has entered an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which provider to use.

Additional information about this option, as well as a list of Network Providers will be given to Covered Employees and updated as needed.

DEDUCTIBLES, CO-PAYMENTS AND OUT-OF-POCKET MAXIMUMS PAYABLE BY COVERED PERSONS

Deductibles and Co-payments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person and per Family Unit. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required.

A co-payment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be co-payments on some services but not others.

BALANCE-BILLING

In the event that a claim submitted by a Network or non-Network Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Covered Person should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance-billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance-billing is legal in many jurisdictions, and the Plan has no control over non-Network Providers that engage in balance-billing practices.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Covered Person should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance-billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance-billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Covered Person is responsible for payment of co-insurances, deductibles, and out-of-pocket maximums and may be billed for any or all of these.

CLAIMS AUDIT

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Plan Document.

HOSTCARE - PRICE NEGOTIATED PROVIDERS – "CONSUMER OPTION"

As a Covered Person in the Plan you sometimes have the ability to control costs for the Plan and for yourself. Through Hostcare Resources this Plan has access to a select group of providers that offer consumer driven options. These providers are referred to as "Price Negotiated Providers." By using Price Negotiated Providers, you save and the Plan saves. Please contact the Medical Concierge at 1-877-654-6229 or through e-mail at mcs@akesocare.com and they will provide you the information you need.

Covered procedures/services that fall outside the Price Negotiated Providers will be considered under the current Plan Benefits.

If you qualify, when you use a Price Negotiated Provider for a treatment or medical service that is a Covered Expense under the Plan, the Plan will pay the Covered Expense at 100%. There is no deductible or co-payment for the Covered Expenses received at Price Negotiated Providers, and you may be eligible for approved reasonable travel costs, meals, accomodation costs and/or cash incentives. The Plan is able to do this because these providers generally offer transparent and direct pricing that allows everyone to know the price for the service upfront.

Each Covered Person has a free choice to use any Provider for the treatment of any medical condition. You are not required to use any Price Negotiated Providers. If you wish to use the Price

Negotiated Providers, you will start by contacting the Medical Concierge at 1-877-654-6229 or through e-mail at msc@akesocare.com. You and your physician are ultimately responsible for determining the appropriate course of medical treatment. Neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any provider. It is important that you be familiar with the services offered by the Price Negotiated Providers and that you make an appropriate evaluation of the services offered.

This option provides payment only for services that are otherwise covered. If you use a Price Negotiated Provider for a service that is **not** covered under the Plan, the Plan will **not** pay for the service. This option is subject to the Plan exclusions, limitations or other restrictions listed in the Plan which may apply.

PPO PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
ESSENTIAL BENEFITS – MAXIMUM ANNUAL BENEFIT AMOUNT	UNLIMITED	
Note: *The maximums listed are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total that may be split between Network and Non-Network Providers.*		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$750.00	$750.00
Per Family Unit	$1,250.00	$1,250.00
CO-PAYMENTS *The following Co-payments do not apply towards the Calendar Year Out-of-Pocket maximums.*		
• **Physician Visits**	$30.00	Not Applicable
• **Specialist Visits**	$45.00	Not Applicable
• **Urgent Care**	$60.00	Not Applicable
CO-PAYMENTS *The following Co-payments apply towards the Calendar Year Out-of-Pocket maximums.*		
• **Inpatient Hospital Facility**	First day: $100.00 Each day thereafter: $50.00	First day: $250.00 Each day thereafter: $50.00
• **Outpatient Surgical Facility** *For surgeries where the facility stay is less than 23 hours*	$100.00	$300.00
MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR *(Not including deductible)*		
Per Covered Person	$1,500.00	$1,750.00
Per Family Unit	$4,500.00	$5,250.00
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: • **Inpatient/Outpatient Mental Health treatment charges** • **Inpatient/Outpatient Substance Abuse treatment charges** • **Bariatric Surgery Charges** • **Cost containment penalties** • **Physician Visit, Specialist Visits and Urgent Care Co-payments** • **Charges above Reasonable & Customary**		
COVERED CHARGES		
HOSPITAL AND FACILITY SERVICES		
When a Network Hospital and Physician have been selected and a Non-Network anesthesiologist, radiologist, pathologist or assistant surgeon is assigned, these providers will be paid at the Network level of benefits, subject to the Reasonable and Customary Charge. If a Network Hospital is utilized for services for a Medical Emergency, the emergency room Physician will be payable at the Network level of benefits subject to the Reasonable and Customary Charge. ***Note:*** *Failure to pre-certify a Hospital admission will result in a penalty of **$500.00**.*		
• **Ambulatory Surgical Center Facility Fee**	80% after Outpatient Surgical Facility co-payment and deductible	70% after deductible

PPO PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
• **Emergency Room**	80% after deductible	70% after deductible
• **Intensive Care Unit**	80% after deductible *of the Hospital's ICU charge*	70% after deductible *of the Hospital's ICU charge*
• **Organ Transplants**	80% after deductible*	70% after deductible

Organ Transplants – "In-Network" Only:

Transplants performed at a Center of Excellence have the following benefits:

Reimbursement of:

- *Travel and Lodging expenses incurred during the entire transplant (immediately before and after the transplant) up to a $5,000.00 maximum for the Covered Person and Companion;*
- *Waiver of the Covered Person's deductible and Out of Pocket expenses up to $1,500.00;*
- *Services of a Transplant Facilitator, who will coordinate the cost savings.*

In order to participate, you must do ALL of the following:

- *Give pre-notification of the upcoming transplant, as soon as the Covered Person is identified as a potential transplant candidate. Pre-notification must be made at 1-888-4ORGANS;*
- *The Covered Person must follow the Plan's standard Pre-Certification requirements and obtain Pre-Certification."*

***Note**: Procedures that are classified as "Experimental and/or investigational" are not covered. The Plan covers a Plan Participant's charges as a donor, whether or not the recipient is a Covered Person.*

PPO PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
• **Outpatient Services** *Not including Emergency Room Care*	80% after deductible	70% after deductible
• **Outpatient Surgery**	80% after Outpatient Surgical Facility co-payment and deductible	70% after deductible
• **Pre-Admission Testing Services**	80% after deductible	70% after deductible
• **Pregnancy** *Dependent daughters covered for pregnancy*	80% after deductible	70% after deductible
• **Room and Board**	80% after deductible *the semiprivate room rate*	70% after deductible *the semiprivate room rate*
• **Routine Well Newborn Care**	80% after deductible	70% after deductible
• **Skilled Nursing Facility**	80% after deductible *of the semi-private room rate;* *Per Confinement Maximum: 180 Days* *Lifetime Maximum Outside Period of Confinement: 60 Days* *Lifetime Maximum for all Confinements: 365 Days*	70% after deductible *of the semi-private room rate;* *Per Confinement Maximum: 180 Days* *Lifetime Maximum Outside Period of Confinement: 60 Days* *Lifetime Maximum for all Confinements: 365 Days*
PREVENTIVE CARE		
• **Routine Well Adult Care**	100% deductible waived when primary purpose of Office Visit is Preventive Care	70% after deductible

PPO PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Routine Well Adult Care includes office visits, pap smears, mammograms, colonoscopy, blood work-cholesterol, general health panel, lipid panel, complete blood count, prostate screening (PSA), gynecological exam, routine physical examinations, Influenza Vaccines and x-rays for the Covered Person and his or her Spouse. If a problem is discovered through a routine exam, all subsequent Covered Charges related to the condition will be payable under Covered Medical expenses.		
• **Routine Well Child Care**	100% deductible waived when primary purpose of Office Visit is Preventive Care	70% after deductible
Routine Well Child Care includes office visits, routine physical examinations, laboratory blood tests, x-rays, Influenza Vaccines and immunizations through age 18.		
PHYSICIAN SERVICES		
• **Abortions (Elective)**	Not Covered	Not Covered
• **Acupuncture**	Not Covered	Not Covered
• **Advanced Imaging** *(CT, MRI, PET Scans)*	80% after deductible	70% after deductible
• **Advanced Imaging through "One Call Medical"** *(CT, MRI, PET Scans)*	100% deductible and co-payment waived	Not Applicable
• **Allergy Injections**	80% after deductible	70% after deductible
• **Ambulance Service**	80% after deductible	80% after deductible
• **Anesthesia**	80% after deductible *if a Network Hospital and Network Physician are utilized*	70% after deductible
• **Assistant Surgeon** *Benefits are subject to surgeries where an Assistant Surgeon is Medically Necessary.*	80% after deductible *if a Network Hospital and Network Physician are utilized*	70% after deductible
• **Bariatric Surgery***	90% of Surgery, deductible waived	Not Covered
***NOTE** - Services must be performed by BariNet to be eligible. Please see the Covered Charges section for more details on coverage for Bariatric Surgery. Bariatric PreSurgical labs, consults, etc. as required by BariNet are subject to normal copays, deductible, and/or coinsurance. This program is only for primary bariatric surgery and excludes revision surgery for previous bariatric surgery procedures. Approved surgical procedures will include laparoscopic gastric bypass, adjustable gastric banding, and laparoscopic sleeve gastrectomy.*		
Please note that these amounts ONLY include costs related to the surgical episode, and that all other charges will be billed to the member's group health plan. The member's portion of the surgical episode does not count towards the OOPM and is never paid at 100%. However, the10% fee is reimbursed to the member over the course of 3 years if guidelines are met.		
• **Bereavement Counseling**	100% deductible waived	100% deductible waived
• **Chemotherapy/Radiation Therapy**	80% after deductible	70% after deductible
• **Chiropractic Services***	80% after deductible	80% after deductible
***Note**: Benefits are payable for Physician's fees or Chiropractic fees for the treatment by manual or mechanical means of structural imbalance, distortion or subluxation in the vertebral column or elsewhere in the body. This manual manipulation of the spine to correct subluxation (vertebrae out of place) that can be demonstrated by x-ray.*		
• **Developmental Delays and Learning Disorders**	Not Covered	Not Covered

PPO PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
• **Dialysis**	80% after deductible	70% after deductible
• **Durable Medical Equipment**	80% after deductible	70% after deductible
• **Emergency Room**	80% after deductible	70% after deductible
• **Foot Orthotics** *Only after an open-cutting operation*	80% after deductible	70% after deductible
• **Hearing Aid**	Not Covered	Not Covered
• **Home Birth**	Not Covered	Not Covered
• **Home Health Care**	80% after deductible *40 visits Calendar Year maximum*	70% after deductible *40 visits Calendar Year maximum*
• **Hospice Care**	100% after deductible	100% after deductible
• **Infertility, Reproductive Enhancement, Genetic Manipulation***	Not Covered	Not Covered
***Note**: Genetic manipulation, including testing, shall be covered to the extent it is considered necessary treatment for purposes of diagnosing a disease or the course of treatment. Subject to the deductible and coinsurance.*		
• **Inpatient Visits**	80% after deductible	70% after deductible
• **Jaw Joint/TMJ***	80% after deductible	80% after deductible
***Note**: Covered charges include examinations, x-rays of the joint, jaw, head, surgery, injections and transcutaneous nerve stimulation. Covered charges that directly treat the teeth (orthodontics, crowns, inlays and any appliance that is attached to or rests on the teeth) whether provided by a dentist or a medical doctor are **not covered expenses**.*		
• **Laboratory/X-Ray Services**	80% after deductible *if a Network Hospital and Network Physician are utilized*	70% after deductible
• **Laboratory Services** *"Lab Card" only*	100% deductible and co-payment waived	Not Applicable
• **Mastectomy/Breast Reconstruction**	80% after deductible	70% after deductible
• **Maternity/Newborn Care**	80% after deductible	70% after deductible
• **Morbid Obesity – Non-Surgical Medically Necessary Treatment**	80% after deductible	70% after deductible
• **Morbid Obesity – Surgical Treatment**	*See "Bariatric Surgery" above; otherwise not covered*	Not Covered
• **Nurse Midwives**	80% after deductible *Inpatient Hospital ONLY; Not Covered for Home Birth*	70% after deductible *Inpatient Hospital ONLY; Not Covered for Home Birth*
• **Obesity**	Not Covered	Not Covered
• **Occupational Therapy** *Does not include charges for developmental delays or learning disorders.*	80% after deductible	70% after deductible
• **Office Visits**	100% after Physician Visit co-payment	70% after deductible
• **Office Visit – Laboratory/X-Ray Services**	80% after deductible	70% after deductible
• **Oral Surgery**	80% after deductible	70% after deductible

PPO PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
• **Outpatient Dialysis Services:**		
• Days 1 – 90 after diagnosis	80% after deductible	70% after deductible
• Days 91 on; until Medicare is primary	100% of 125% of Medicare allowable amount No deductible applies	100% of 125% of Medicare allowable amount No deductible applies
Please refer to the Covered Charges section for more information regarding the Dialysis Services benefit.		
• **Outpatient Private Duty Nursing**	80% after deductible *Calendar Year Maximum: 30 Visits*	70% after deductible *Calendar Year Maximum: 30 Visits*
• **Physical Therapy** *Does not include charges for developmental delays or learning disorders.*	80% after deductible	70% after deductible
• **Prosthetics***	80% after deductible	70% after deductible
***Note**: Replacement prosthetics are covered if the prosthetic is deficient due to normal usage or physical change. The prosthetic replacement is covered no more than 1 every 60 months. Replacement due to loss is not a Covered Expense.*		
• **Second Surgical Opinion**	80% deductible waived	70% deductible waived
• **Specialist Office Visit**	100% after Specialist co-payment	70% after deductible
• **Speech Therapy** *Does not include charges for developmental delays or learning disorders.*	80% after deductible	70% after deductible
• **Surgery – Inpatient**	80% after deductible	70% after deductible
• **Surgery – Outpatient**	80% after deductible	70% after deductible
• **Sterilization**	80% after deductible	70% after deductible
• **Urgent Care/Immediate Care**	100% after co-payment	70% after deductible
• **Wig After Chemotherapy**	80% after deductible	70% after deductible
MENTAL DISORDERS / SUBSTANCE ABUSE / CHEMICAL DEPENDENCY		
• **Inpatient**	80% after deductible *Calendar Year Maximum: 15 Days* *Lifetime Maximum: 30 Days*	70% after deductible *Calendar Year Maximum: 15 Days* *Lifetime Maximum: 30 Days*
• **Partial Hospitalization**	80% after deductible *Calendar Year Maximum: 20 Visits*	70% after deductible *Calendar Year Maximum: 20 Visits*
• **Inpatient/Partial Hospitalization Combined**	80% after deductible *Calendar Year Maximum: 15 Full Days* *Lifetime Maximum: 30 Full Days*	70% after deductible *Calendar Year Maximum: 15 Full Days* *Lifetime Maximum: 30 Full Days*
• **Outpatient**	80% after deductible *Calendar Year Maximum: 20 Visits*	70% after deductible *Calendar Year Maximum: 20 Visits*
***Note**: Failure to pre-certify a Hospital admission will result in a penalty of **$500.00**.*		

PRESCRIPTION DRUG CARD BENEFITS (PPO PLAN)

PHARMACY OPTION (30-DAY SUPPLY)

Co-insurance, per Prescription:

For Generic	Plan deductible applies; No co-insurance
For Brands	20% after deductible

MAIL ORDER PRESCRIPTION DRUG OPTION (90-DAY SUPPLY)

Co-payment, per Prescription:

For Generic	$15.00
For Formulary Name Brands	$30.00
For Non-Formulary Name Brands	$45.00

Note: When a Generic Drug is available and the Covered Person requests the Brand, the Covered Person will pay the Brand co-payment/co-insurance and the difference in the price of the Brand drug. If a physician requires a Brand when a Generic is available, the member pays only the Brand co-payment/co-insurance.

SPECIALTY MEDICATIONS: The Covered Person should contact the prescription drug card vendor for a list of Specialty Medications.

HDHP PLAN	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
ESSENTIAL BENEFITS – MAXIMUM ANNUAL BENEFIT AMOUNT	UNLIMITED	
***Note**: The maximums listed are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total that may be split between Network and Non-Network Providers.*		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$2,450.00	$2,450.00
Per Family Unit*	$4,650.00	$4,650.00
***Note**: *For family coverage, one person has to satisfy* $2,800, *the remaining can be satisfied by one or all family members.*		
MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR ***(Including deductible)***		
Per Covered Person	$2,450.00	$3,250.00
Per Family Unit	$4,650.00	$5,450.00
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: • **Cost containment penalties** • **Charges above Reasonable & Customary**		
COVERED CHARGES		
HOSPITAL AND FACILITY SERVICES		
When a Network Hospital and Physician have been selected and a Non-Network anesthesiologist, radiologist, pathologist or assistant surgeon is assigned, these providers will be paid at the Network level of benefits, subject to the Reasonable and Customary Charge. If a Network Hospital is utilized for services for a Medical Emergency, the emergency room Physician will be payable at the Network level of benefits subject to the Reasonable and Customary Charge. ***Note**: Failure to pre-certify a Hospital admission will result in a penalty of **$500.00**.*		
• **Ambulatory Surgical Center Facility Fee**	100% after deductible	70% after deductible
• **Emergency Room**	100% after deductible	70% after deductible
• **Intensive Care Unit**	100% after deductible *of the Hospital's ICU charge*	70% after deductible *of the Hospital's ICU charge*
• **Organ Transplants**	100% after deductible*	70% after deductible

HDHP PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS

Organ Transplants – "In-Network" Only:

Transplants performed at a Center of Excellence have the following benefits:

Reimbursement of:

- *Travel and Lodging expenses incurred during the entire transplant (immediately before and after the transplant) up to a $5,000.00 maximum for the Covered Person and Companion;*
- *Waiver of the Covered Person's deductible and Out of Pocket expenses up to $1,500.00;*
- *Services of a Transplant Facilitator, who will coordinate the cost savings.*

In order to participate, you must do ALL of the following:

- *Give pre-notification of the upcoming transplant, as soon as the Covered Person is identified as a potential transplant candidate. Pre-notification must be made at 1-888-4ORGANS;*
- *The Covered Person must follow the Plan's standard Pre-Certification requirements and obtain Pre-Certification."*

Note: *Procedures that are classified as "Experimental and/or investigational" are not covered. The Plan covers a Plan Participant's charges as a donor, whether or not the recipient is a Covered Person.*

HDHP PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
• **Outpatient Services** *Not including Emergency Room Care*	100% after deductible	70% after deductible
• **Outpatient Surgery**	100% after deductible	70% after deductible
• **Pre-Admission Testing Services**	100% after deductible	70% after deductible
• **Pregnancy** *Dependent daughters covered for pregnancy*	100% after deductible	70% after deductible
• **Room and Board**	100% after deductible *the semiprivate room rate*	70% after deductible *the semiprivate room rate*
• **Routine Well Newborn Care**	100% after deductible	70% after deductible
• **Skilled Nursing Facility**	100% after deductible *of the semi-private room rate; Per Confinement Maximum: 180 Days Lifetime Maximum Outside Period of Confinement: 60 Days Lifetime Maximum for all Confinements: 365 Days*	70% after deductible *of the semi-private room rate; Per Confinement Maximum: 180 Days Lifetime Maximum Outside Period of Confinement: 60 Days Lifetime Maximum for all Confinements: 365 Days*
PREVENTIVE CARE		
• **Routine Well Adult Care**	100% deductible waived when primary purpose of Office Visit is Preventive Care	70% after deductible

Routine Well Adult Care includes office visits, pap smears, mammograms, colonoscopy, blood work-cholesterol, general health panel, lipid panel, complete blood count, prostate screening (PSA), gynecological exam, routine physical examinations, Influenza Vaccines and x-rays for the Covered Person and his or her Spouse. If a problem is discovered through a routine exam, all subsequent Covered Charges related to the condition will be payable under Covered Medical expenses.

Colonoscopies and Sigmoidoscopies are only covered if In Network.

HDHP PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
• **Routine Well Child Care**	100% deductible waived when primary purpose of Office Visit is Preventive Care	70% after deductible
Routine Well Child Care includes office visits, routine physical examinations, laboratory blood tests, x-rays, Influenza Vaccines and immunizations through age 18.		
PHYSICIAN SERVICES		
• **Abortions (Elective)**	Not Covered	Not Covered
• **Acupuncture**	Not Covered	Not Covered
• **Advanced Imaging** *(CT, MRI, PET Scans)*	100% after deductible	70% after deductible
• **Advanced Imaging through "One Call Medical"** *(CT, MRI, PET Scans)*	100% after deductible	Not Applicable
• **Allergy Injections**	100% after deductible	70% after deductible
• **Ambulance Service**	100% after deductible	70% after deductible
• **Anesthesia**	100% after deductible *if a Network Hospital and Network Physician are utilized*	70% after deductible
• **Assistant Surgeon** *Benefits are subject to surgeries where an Assistant Surgeon is Medically Necessary.*	100% after deductible *if a Network Hospital and Network Physician are utilized*	70% after deductible
• **Bariatric Surgery***	100% of Surgery, after $1,000 co-payment and deductible	Not Covered
***NOTE** - Services must be performed by BariNet to be eligible. Please see the Covered Charges section for more details on coverage for Bariatric Surgery. Bariatric PreSurgical labs, consults, etc. as required by BariNet are subject to normal copays, deductible, and/or coinsurance. This program is only for primary bariatric surgery and excludes revision surgery for previous bariatric surgery procedures. Approved surgical procedures will include laparoscopic gastric bypass, adjustable gastric banding, and laparoscopic sleeve gastrectomy.*		
Please note that these amounts ONLY include costs related to the surgical episode, and that all other charges will be billed to the member's group health plan. The member's portion of the surgical episode does not count towards the OOPM and is never paid at 100%. However, the10% fee is reimbursed to the member over the course of 3 years if guidelines are met.		
• **Bereavement Counseling**	100% after deductible	70% after deductible
• **Chemotherapy/Radiation Therapy**	100% after deductible	70% after deductible
• **Chiropractic Services***	100% after deductible	70% after deductible
***Note**: Benefits are payable for Physician's fees or Chiropractic fees for the treatment by manual or mechanical means of structural imbalance, distortion or subluxation in the vertebral column or elsewhere in the body. This manual manipulation of the spine to correct subluxation (vertebrae out of place) that can be demonstrated by x-ray.*		
• **Developmental Delays and Learning Disorders**	Not Covered	Not Covered
• **Dialysis**	100% after deductible	70% after deductible
• **Durable Medical Equipment**	100% after deductible	70% after deductible
• **Emergency Room**	100% after deductible	70% after deductible

HDHP PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
• **Foot Orthotics** *Only after an open-cutting operation*	100% after deductible	70% after deductible
• **Hearing Aid**	Not Covered	Not Covered
• **Home Birth**	Not Covered	Not Covered
• **Home Health Care**	100% after deductible *40 visits Calendar Year maximum*	70% after deductible *40 visits Calendar Year maximum*
• **Hospice Care**	100% after deductible	70% after deductible
• **Infertility, Reproductive Enhancement, Genetic Manipulation***	Not Covered	Not Covered
***Note**: Genetic manipulation, including testing, shall be covered to the extent it is considered necessary treatment for purposes of diagnosing a disease or the course of treatment. Subject to the deductible and coinsurance.*		
• **Inpatient Visits**	100% after deductible	70% after deductible
• **Jaw Joint/TMJ***	100% after deductible	70% after deductible
***Note**: Covered charges include examinations, x-rays of the joint, jaw, head, surgery, injections and transcutaneous nerve stimulation. Covered charges that directly treat the teeth (orthodontics, crowns, inlays and any appliance that is attached to or rests on the teeth) whether provided by a dentist or a medical doctor are **not covered expenses**.*		
• **Laboratory/X-Ray Services**	100% after deductible *if a Network Hospital and Network Physician are utilized*	70% after deductible
• **Mastectomy/Breast Reconstruction**	100% after deductible	70% after deductible
• **Maternity/Newborn Care**	100% after deductible	70% after deductible
• **Morbid Obesity – Non-Surgical Medically Necessary Treatment**	100% after deductible	70% after deductible
• **Morbid Obesity – Surgical Treatment**	*See "Bariatric Surgery" above; otherwise not covered*	Not Covered
• **Nurse Midwives**	100% after deductible *Inpatient Hospital ONLY; Not Covered for Home Birth*	70% after deductible *Inpatient Hospital ONLY; Not Covered for Home Birth*
• **Obesity**	Not Covered	Not Covered
• **Occupational Therapy** *Does not include charges for developmental delays or learning disorders.*	100% after deductible	70% after deductible
• **Office Visits**	100% after deductible	70% after deductible
• **Office Visit – Laboratory/X-Ray Services**	100% after deductible	70% after deductible
• **Oral Surgery**	100% after deductible	70% after deductible
• **Outpatient Dialysis Services:**		
• Days 1 – 90 after diagnosis	100% after deductible	70% after deductible
• Days 91 on; until Medicare is primary	100% of 125% of Medicare allowable amount No deductible applies	100% of 125% of Medicare allowable amount No deductible applies

HDHP PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Please refer to the Covered Charges section for more information regarding the Dialysis Services benefit.		
• **Outpatient Private Duty Nursing**	100% after deductible *Calendar Year Maximum: 30 Visits*	70% after deductible *Calendar Year Maximum: 30 Visits*
• **Physical Therapy** *Does not include charges for developmental delays or learning disorders.*	100% after deductible	70% after deductible
• **Prosthetics***	100% after deductible	70% after deductible
***Note**: Replacement prosthetics are covered if the prosthetic is deficient due to normal usage or physical change. The prosthetic replacement is covered no more than 1 every 60 months. Replacement due to loss is not a Covered Expense.*		
• **Second Surgical Opinion**	100% after deductible	70% after deductible
• **Specialist Office Visit**	100% after deductible	70% after deductible
• **Speech Therapy** *Does not include charges for developmental delays or learning disorders.*	100% after deductictfble	70% after deductible
• **Surgery – Inpatient**	100% after deductible	70% after deductible
• **Surgery – Outpatient**	100% after deductible	70% after deductible
• **Sterilization**	100% after deductible	70% after deductible
• **Urgent Care/Immediate Care**	100% after deductible	70% after deductible
• **Wig After Chemotherapy**	100% after deductible	70% after deductible
MENTAL DISORDERS / SUBSTANCE ABUSE / CHEMICAL DEPENDENCY		
• **Inpatient**	100% after deductible *Calendar Year Maximum: 15 Days* *Lifetime Maximum: 30 Days*	70% after deductible *Calendar Year Maximum: 15 Days* *Lifetime Maximum: 30 Days*
• **Partial Hospitalization**	100% after deductible *Calendar Year Maximum: 20 Visits*	70% after deductible *Calendar Year Maximum: 20 Visits*
• **Inpatient/Partial Hospitalization Combined**	100% after deductible *Calendar Year Maximum: 15 Full Days* *Lifetime Maximum: 30 Full Days*	70% after deductible *Calendar Year Maximum: 15 Full Days* *Lifetime Maximum: 30 Full Days*
• **Outpatient**	100% after deductible *Calendar Year Maximum: 20 Visits*	70% after deductible *Calendar Year Maximum: 20 Visits*
***Note**: Failure to pre-certify a Hospital admission will result in a penalty of **$500.00**.*		

PRESCRIPTION DRUG CARD BENEFITS (HDHP PLAN)

PHARMACY OPTION (30-DAY SUPPLY) – DISCOUNT ONLY CARD

Plan Pays:	NETWORK	NON-NETWORK
For Generic	100% after deductible	70% after deductible
For Formulary Name Brands	100% after deductible	70% after deductible
For Non-Formulary Name Brands	100% after deductible	70% after deductible
Contraceptive Medications *(only Oral and Transdermal are covered)*	100% after deductible	70% after deductible

MAIL ORDER PRESCRIPTION DRUG OPTION (90-DAY SUPPLY)

Plan Pays:	NETWORK	NON-NETWORK
For Generic	100% after deductible	70% after deductible
For Formulary Name Brands	100% after deductible	70% after deductible
For Non-Formulary Name Brands	100% after deductible	70% after deductible

Note: When a Generic Drug is available and the Covered Person requests the Brand, the Covered Person will pay the co-insurance and the difference in the price of the Brand drug. If a physician requires a Brand when a Generic is available, the member pays only the co-insurance.

SPECIALTY MEDICATIONS: The Covered Person should contact the prescription drug card vendor for a list of Specialty Medications.

MEDICAL BENEFITS

Medical benefits may be available when a Covered Person Incurs Covered Charges for care of an Injury or Sickness while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount – A deductible is an amount of money that is paid once a Calendar Year per Covered Person and per Family Unit. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges.

Family Unit Limit – When the amount shown in the Schedule of Benefits has been Incurred by members of a Family Unit toward their Calendar Year Deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductibles and any co-payments (if applicable), subject to all other Plan provisions, exclusions and limitations. Payment will be made at the percentage shown in the Schedule of Benefits. No benefits will be paid in excess of any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Each Calendar Year Covered Charges are payable at the percentages shown until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges Incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

COVERED CHARGES

"Covered Charges" are the Reasonable and Customary Charges that are Incurred for the following services and supplies. These charges are subject to the benefit limits, exclusions and other provisions of this Plan.

1. **Hospital Care:** the medical services and supplies furnished by a Hospital, Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

   Room charges made by a Hospital having only private rooms will be paid at 90% of the average private room rate. Room charges for a private room prescribed by a Physician due to a contagious disease or contagious infection or other medically necessary reason will be considered a covered expense.

   Charges for Outpatient Hospital Care will be payable as shown in the Schedule of Benefits.

   Charges for Emergency Room Care will be payable as shown in the Schedule of Benefits.

   Charges for an Intensive Care Unit Stay will be payable as shown in the Schedule of Benefits.

2. **Coverage of Pregnancy:** the Reasonable and Customary Charges for the care and treatment of Pregnancy are covered the same as any other Sickness and will be payable as shown in the Schedule of Benefits.

   Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; however, Federal law generally does not prohibit the mother's or newborn's attending provider,

after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

3. **Skilled Nursing Facility Care:** the room and board, nursing care and other services and supplies furnished by a Skilled Nursing Facility will be payable if and when:

   a) The patient is confined as a bed patient in the facility, and

   b) The confinement starts within 14 days of a Hospital confinement of at least 3 days; and

   c) The attending Physician completes a treatment plan that includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

   Covered Charges for a Covered Person's care in these facilities is shown in the Schedule of Benefits.

4. **Physician Care:** the professional services of a Physician for surgical or medical services. These services will be payable as shown in the Schedule of Benefits.

   a) Charges for **multiple surgical procedures** will be a Covered Charge, subject to the following provisions:

      (i) if bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Reasonable and Customary Charge that is allowed for the primary procedure; 50% of the Reasonable 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;

      (ii) if two or more surgeons on separate operative fields perform multiple unrelated surgical procedures, benefits will be based on the Reasonable and Customary Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Reasonable and Customary Charge percentage allowed for that procedure; and

      (iii) if an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Reasonable and Customary Charge allowance.

5. **Private Duty Nursing Care:** the private duty nursing care by a licensed nurse (R.N., L.P.N., or L.V.N.). These benefits will be payable as shown in the Schedule of Benefits. Covered Charges for this service will be included to this extent:

   a) **Inpatient Nursing Care:** charges are covered only when care is Medically Necessary or not Custodial Care and the Hospital Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

   b) **Outpatient Nursing Care:** charges are covered only when care is Medically Necessary and not Custodial Care. The only charges covered for Outpatient Nursing Care are those shown below, under "Home Health Care Services and Supplies".

6. **Home Health Care Services and Supplies:** charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Sickness when Skilled Nursing Facility confinement would otherwise be required. These benefits will be payable as shown in the Schedule of Benefits. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care plan.

   Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A Home Health Care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

7. **Hospice Care Services and Supplies:** charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care plan.

   Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or covered Dependent Children). Bereavement services must be furnished within six months after the patient's death.

   Covered Charges for Hospice Care Services and Supplies, and bereavement counseling are payable as described in the Schedule of Benefits.

8. **Other Medical Services and Supplies:** the services and supplies listed below, not otherwise included in the items above, or listed in the Exclusion Section, will be payable as any other Illness or as shown in the Schedule of Benefits:

   a) Local Medically Necessary professional land or air **Ambulance Service**.

   b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

   c) Charges for **Bariatric Surgery** will be payable as shown in the Schedule of Benefits. **Benefits are only available when a member utilizes the BariNet provider network by calling 1-800-358-9903.**

      Covered Charges

      BariNet Program Requirements:

      The eligible member must comply with the following requirements to receive the incentive:

      1. Verification of Benefits
      2. Candidates for bariatric surgery must be at least 18 years of age
      3. The candidate must have a BMI of one of the following:
         a. BMI of 40 or more;
         b. BMI of 35 or greater with at least two (2) accompanying weight-related co-morbid conditions including but not limited to diabetes, hypertension, hyperlipidemia, sleep apnea with CPAP/BIPAP, etc. and may be determined by the Plan.
      4. Attend Info session by BariNet Provider
      5. Evaluation by BariNet Provider
         - Physical examination and verification of co-morbid conditions
         - Appropriate medical referral for any identified complicating medical condition
      6. Medical Weight Management by a BariNet Provider for three (3) consecutive months prior to, but within 1 year of surgery.
      7. Nutritional evaluation by dietician
      8. Psychological evaluation by Psychologist
      9. Completion of preoperative medical workup:
         - Laboratory examination
         - Radiological evaluation (chest x-ray, UGI) and EKG
         - Review of psychological evaluation
         - Review for completion of educational and nutritional evaluations
      10. Preoperative visit with review of the surgical plan and postoperative requirements
          - *Patients are responsible for any copayment or deductible that is required*

11. Surgery at a BariNet facility
12. Post-surgical follow up as directed by BariNet Surgeon (required to be eligible for incentive reimbursement)
13. Complete one mandatory post-op psychological evaluation yearly following surgery
14. Attend at least three (3) support group meetings within the first 6 months following surgery to be eligible for incentive reimbursement.
15. Attend follow up appointments after surgery (Ex: 3 weeks, 6 months, 12 months, and yearly thereafter)

- If program member is not actively participating in pre and post-operative program requirement, then the member will NOT be eligible for reimbursement of the incentive amount ($1,000 copayment).

Incentive Reimbursement

Program members may qualify for reimbursement of their $1,000 copayment incentive if the following criteria are met:

1. 1 year post- surgery, program member must have attained 40% targeted weight loss, with an additional loss of 10% at year 2, and an additional 5% at year 3. Weight loss target to be determined by BariNet provider and agreed upon by program member prior to surgery.
2. Reimbursement will be 1/3 each completed year for 3 years.
3. You must maintain Health Plan enrollment to be eligible. COBRA meets this requirement also.
4. Reimbursement request forms are to be completed by both BariNet provider and program member attesting to adherence to program requirement. Forms are available from BariNet provider.
5. Out of pocket expenses related to services in preparation for surgery are not eligible for reimbursement.

Complications & Revisions

Only the initial procedure is covered. Revisions are not covered. Complications are covered through BariNet if all requirements are followed. The member should consult with BariNet at 1-800-355-8195 or your BariNet Provider for more information

d) **Cardiac Rehabilitation** as deemed Medically Necessary, provided services are rendered (i) under the supervision of a Physician; (ii) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (iii) initiated within 12 weeks after other treatment for the medical condition ends; and (iv) in a Medical Care Facility.

e) Radiation or **Chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

f) **Chiropractic Services** by a licensed M.D., D.O. or D.C. All services rendered by a chiropractor are subject to the maximum shown in the Schedule of Benefits.

g) **Cleft Lip and Cleft Palate:** Benefits are payable for charges Incurred in connection with the management of birth defects known as cleft lip and cleft palate. These charges must be Incurred while a person is covered for these benefits. These benefits are subject to the provisions of the Plan. They are in place of all other benefits to which a person is entitled under all other parts of the Plan with respect to the same amount of such charges.

Covered expenses for the treatment in the management of birth defects known as cleft lip and cleft palate will include, but are not limited to, inpatient or outpatient expenses arising from:

(i) medical treatment; and

(ii) dental treatment (including orthodontic and oral surgery treatment).

These charges will be paid to the same extent as for any other sickness.

Covered charges do not include charges for services and supplies:

(i) that are not ordered by a doctor;

(ii) for cosmetic reasons, including charges to personalize a denture;

(iii) from a health department maintained by an employer, a union, a trustee or similar type of entity;

(iv) in a Veteran's Administration Hospital unless the Covered Person would legally have to pay if there were no coverage; and

(v) for which a Covered Person would not legally have to pay if there were no coverage.

h) Coverage for individuals participating in Approved **Clinical Trials** (under the Patient Protection and Affordable Care Act of 2010 (PPACA).

i) Initial **Contact Lenses or Glasses** required following cataract surgery.

j) Charges for the rental or purchase of **Durable Medical Equipment**, whichever is economically justified. Repair or replacement of purchased Durable Medical Equipment which is due to the growth and development of the participant and/or when Medically Necessary and not as the result of loss, theft or damage will be considered an eligible expense. Replacement of purchased Durable Medical Equipment due to equipment failure will be covered only once in a five (5) year period. Routine maintenance of the equipment is not an eligible expense.

k) Medically Necessary services for care and treatment of **Jaw Joint Conditions including Temporomandibular Joint Syndrome (TMJ)** as shown in the Schedule of Benefits.

l) **Laboratory Studies**.

m) Treatment of **Mental Disorders and Substance Abuse**. Covered Charges for care, supplies and treatment of Mental Disorders and Substance Abuse must be provided by or under the direction of one of the following professionals, subject to the stated billing requirements:

(i) all treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

(ii) Physician's visits are limited to one treatment per day.

(iii) Psychiatrists (M.D.), Psychologists (Ph.D.), Licensed Clinical Social Workers (LCSW) or Counselors may bill the Plan directly. Other licensed Mental Health Practitioners must be under the direction of and must bill the Plan through these professionals.

n) Injury to or care of **Mouth, Teeth and Gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

(i) excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth;

(ii) emergency repair due to Injury to sound natural teeth sustained while covered. This does not include charges for repair or replacement of any denture. This repair must be made within 12 months from the date of an accident;

(iii) surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth;

(iv) excision of benign bony growths of the jaw and hard palate;

(v) external incision and drainage of cellulitis;

(vi) incision of sensory sinuses, salivary glands or ducts;

(vii) removal of impacted teeth;

(viii) reduction of dislocations and excision of Temporomandibular Joints (TMJ's); and/or

(ix) Hospital and physician charges if Hospital confinement is ordered by a Physician because life or health of patient is endangered if not confined for surgical procedure.

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

o) **Occupational Therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function, subject to any limits as shown in the Schedule of Benefits. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

p) **Organ Transplant** charges covered under the Plan that are Incurred for care and treatment due to an organ or tissue transplant and are subject to these limits:

(i) the transplant must be performed to replace an organ or tissue.

(ii) as shown in the Schedule of Benefits.

Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. Donor charges will be paid under the plan of the recipient. Donor charges include those for:

(i) search, procurement and evaluation of the organ or tissue;

(ii) removing the organ or tissue from the donor; and

(iii) transportation of the organ or tissue within the United States or Canada to the place where the transplant is to take place.

q) The initial purchase, fitting and repair of **Orthotic Appliances** such as braces, splints or other appliances that are required for support after an open-cutting operation only, subject to any limits as shown in the Schedule of Benefits.

r) **Outpatient Dialysis Services**. WaNee Community Schools, has contracted with *Advantia Dialysis Claims Solutions* to provide cost solutions for a Covered Person diagnosed with End Stage Renal Disease ("ESRD"). If a Covered Person is diagnosed with End Stage Renal Disease ("ESRD"), the Covered Person may be eligible for Medicare coverage by nature of being diagnosed with ESRD. The Covered Person is not obligated by the Plan to apply for Medicare Part A and/or Part B. That said, if you or your covered dependent is diagnosed with ESRD, the following benefits will apply.

Once the member or dependent becomes, **or is eligible to become**, qualified for Medicare coverage for ESRD and Medicare becomes or is eligible to become the Secondary Payer for ESRD services, the Plan will pay claims for ESRD services at 125% of the then current Medicare Allowable for ESRD Services.

Once the member or dependent becomes, **or is eligible to become**, qualified for Medicare coverage for ESRD and Medicare becomes or is eligible to become the Primary Payer for ESRD services, the Plan will pay claims for ESRD services at 100% of the then current Medicare Allowable for ESRD Services.

Notwithstanding the above, the Plan may, at its sole discretion, agree to a contractual arrangement for payment with a provider of ESRD services. The contract may allow for a different payment for ESRD services than listed above but in no circumstances will a contractual arrangement allow for a payment less than the payments listed above.

In order to ensure the correct coordination of claims payments between the Plan and Medicare, members are required to provide the Plan Administrator with the effective date of Medicare coverage."

s) **Physical Therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and to improve a body function, subject to any limits as shown in the Schedule of Benefits.

t) **Prescription Drugs,** subject to any limits as shown in the Schedule of Benefits.

u) The initial purchase, fitting and repair of fitted **Prosthetic Devices** that replace body parts, subject to any limits as shown in the Schedule of Benefits.

v) **Reconstructive Surgery:** correction of abnormal congenital conditions and reconstructive mammaplasties will be considered Covered Charges. This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed;

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the patient.

w) **Routine Preventive Care:** Covered Charges under Medical Benefits are payable for Routine Preventive Care as shown in the Schedule of Benefits.

Routine Well Adult and Child Care is routine care by a Physician that is not for an Injury or Sickness.

x) **Speech Therapy** by a licensed speech therapist, subject to any limits as shown in the Schedule of Benefits. Therapy must be ordered by a Physician and follow either:

(i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person;

(ii) an Injury; or

(iii) a Sickness that is other than a learning or Mental Disorder.

y) **Sterilization Procedures,** subject to any limits as shown in the Schedule of Benefits.

z) **Surgical Dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

aa) Coverage of **Well Newborn Nursery/Physician Care**.

Routine Well Newborn Nursery Care is room, board and other normal care for which a Hospital makes a charge. These benefits will be payable as shown in the Schedule of Benefits.

This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn child is an eligible Dependent. The newborn Child of a covered Dependent is not eligible for this benefit.

The benefit is limited to Reasonable and Customary Charges for nursery care while the newborn child is Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn Child.

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

Routine Physician Care is limited to Reasonable and Customary Charges made by a Physician for routine pediatric care while the newborn Child is Hospital confined.

Charges for covered routine Physician care will be applied toward the Plan of the newborn Child.

bb) Charges associated with the initial purchase of a **Wig after Chemotherapy,** subject to any limits as shown in the Schedule of Benefits.

cc) Diagnostic **X-rays,** subject to any limits as shown in the Schedule of Benefits.

COST MANAGEMENT SERVICES

COST MANAGEMENT SERVICES PHONE NUMBER

Please refer to the Employee ID Card for the Cost Management Services telephone number.

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 48 hours in advance of services being rendered or within 48 hours after an emergency.

Note: *Any reduced reimbursement due to failure to follow Cost Management procedures will not accrue toward the 100% maximum out-of-pocket payment.*

UTILIZATION REVIEW

Utilization review is required to pre-certify inpatient hospitalization days and certain medical procedures. The program consists of:

1. pre-certification for the following non-emergency services before medical and/or surgical services are provided:
   - **Inpatient Hospitalization**
   - **Scheduled Outpatient Surgery requiring implants** (i.e. pacemaker/defibrillators, cataracts, cochlear implants)
   - **Chemotherapy**
   - **Radiation**

   NOTE: The following Outpatient Services DO NOT require pre-certification:
   - **Ultrasounds**
   - **Blood Tests**
   - **EEG's**
   - **Echos**
   - **Simple X-Rays**
   - **EMG's**
   - **EKG's**
   - **Flexible Sigmoidoscopies**
2. retrospective review of emergency inpatient admissions;
3. concurrent review, based on the admitting diagnosis, when an extension of the pre-certified inpatient days is requested by the attending Physician; and
4. certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The attending Physician does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Utilization Review is required for non-emergency and emergency Hospital admissions. The utilization review administrator does not approve employee or Dependent eligibility for Plan benefits. All claims must be submitted to the Plan for processing to determine the amount of benefits, if any, to be paid under the terms of the Plan.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider. If a particular course of treatment or medical service is not certified, it means that the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

The Covered Person is free to choose any Physician or surgeon, and the Physician-patient relationship shall be maintained. The Covered Person, together with the treating Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

In order to maximize Plan reimbursements, please read the following provisions carefully.

HERE'S HOW THE PROGRAM WORKS:

Pre-Certification – Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrators will, in conjunction with the attending Physician, certify the number of inpatient Hospital days that are approved. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance. Pre-certification is not a guarantee that services will be paid.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least 48 hours before** services are scheduled to be rendered with the following information:

- the name of the patient and relationship to the covered Employee,
- the name, identification number and address of the covered Employee,
- the name of the Employer,
- the name and telephone number of the attending Physician,
- the name of the Medical Care Facility, proposed date of admission, and proposed length of stay,
- the diagnosis and/or type of surgery, and
- the proposed rendering of listed medical services.

If there is an **emergency admission** to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** of the first business day after the emergency inpatient admission.

The utilization review administrator will authorize the number of days of Medical Care Facility confinement. **Failure to follow this procedure may reduce reimbursement received from the Plan. If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced as shown in the Schedule of Benefits.**

Concurrent Review/Discharge Planning – Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-certified, the attending Physician must request the additional services or days no later than 24 hours before the end of the original pre-certified number of days or services.

REMEMBER:

1. Call the utilization review administrator before all non-emergency inpatient Hospital stays and within 48 hours of the first business day after an emergency inpatient admission.

2. The utilization review administrator reviews and approves hospitalization days based on the Physician's diagnosis and treatment plan. It does not approve Employee or Dependent eligibility, and it does not approve charges as Covered Charges under the Plan. All claims must be submitted to the Plan for processing under Plan terms.

3. If you do not follow the utilization review procedures, payment for Covered Charges under the Plan will be reduced.

CASE MANAGEMENT

When a catastrophic condition, such as a spinal cord Injury, cancer, AIDS, or a premature birth occurs, a person may require long-term, perhaps lifetime, care. After the person's condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting – even to his or her home.

Case Management is a program whereby a case manager monitors these patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician. 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 necessary equipment and services.

Case Management occurs when this alternate 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 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.*

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.

CONCIERGE PROGRAM

This Plan includes a Medical Concierge Program. The Concierge Program is designed to assist the Covered Person in locating the highest quality provider (based upon national statistics) for services rendered. Providers approved by the Concierge are authorized to be paid as Network Providers. The Concierge will negotiate with the selected Provider for the best reimbursement rate for both the Covered Person and the Plan costs, which in turn will help premium costs.

The Covered Person will need to contact the Concierge prior to scheduling the following services; the Concierge phone number is listed on the Covered Person's ID card:

- **Inpatient Hospital Services**, **including**: Surgery, medical, maternity and cardiac
- **Outpatient Surgeries**: Defined as follows: Any operative procedure done at a free-standing or hospital setting by a physician to correct, repair, diagnose and/or cure an identified medical condition, disease or injury. (Includes colonoscopies)
- **Chemotherapy**
- **Radiation Treatment**

- **PET Scan, MRI or CT Scan**
- **Home Health Care**
- **Transplant workups**
- **Durable Medical Equipment over $5,000.00**
- **Kidney Dialysis**

NOTE: A Provider calling for Pre-certification does not satisfy the Covered Person's obligation to call the Concierge and will result in a penalty of $250.00. Failure to follow Pre-certification and/or Medical Concierge requirements will each result in a penalty of $250.00.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

ADA means the American Dental Association.

Active Employee is an Employee who is on the regular payroll of the Employer and who is scheduled to perform the duties of his or her job with the Employer on a full-time or part-time basis. Where the Plan requires a Waiting Period, an Employee shall be deemed to be an Active Employee if the Employee is absent from work due to a health factor on any day of the Waiting Period, including the first day of Plan coverage on completion of the Waiting Period. Where the Plan does not require a Waiting Period, in order for an Employee's coverage to become effective, an Employee must begin work.

Adverse Benefit Determination means any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A rescission of coverage;
4. A termination of benefits; or
5. 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.

Allowable Charge means the Usual and Customary charge for any Medically Necessary, Reasonable, and eligible items of expense, at least a portion of which is covered under a Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations Section, this Plan's Allowable Charge shall in no event exceed the Other Plan's Allowable Charge. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO Provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO Provider, this Plan will not consider as Allowable Expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO Provider.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Baseline shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where birth occurs in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means January 1st through December 31st of the same year.

Child and/or Children means, 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.

CHIP refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

Chiropractic Service(s) relates to all care rendered in a chiropractor's office, and includes but is not limited to 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 is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

Claims Administrator means the third party administrator which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims.

Clean Claim is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim: A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Covered Person has failed to submit required forms or additional information to the Plan as well.

Clinical Trial means trials to evaluate the effectiveness and safety of medications or medical devices by monitoring their effects on large groups of people. This Plan cannot:

1. deny an individual participation in an approved clinical trial conducted in relation to prevention, detection or treatment of cancer or another life-threatening disease or condition;

2. deny, limit or impose additional conditions on the Plan's coverage for items and services furnished in connection with participation in the clinical trial if the items or services would ordinarily be covered under the plan if the individual were not enrolled in the clinical trial; or

3. discriminate against an individual on the basis of his or her participation in the clinical trial.

Clinical Trial - Approved is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening disease or condition that is likely to result in death unless the course of the condition is interrupted. In addition, the clinical trial must be a study or investigation conducted under a new drug application reviewed by the Food and Drug Administration (or be exempt from having such an investigational new drug application) or the trial must be approved or funded by specified government agencies.

Routine patient costs are a Covered Expense when performed in an Approved Clinical Trial.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Complications of Pregnancy are determined as follows:

These conditions are included before the Pregnancy ends: acute nephritis; ectopic Pregnancy; miscarriage; nephrosis, cardiac decompensation; missed abortion; hyperemesis gravidarum; and eclampsia of Pregnancy.

Other Pregnancy related conditions will be covered that are as medically severe as those listed.

These conditions are **not** included: false labor; occasional spotting; rest during Pregnancy even if prescribed by a Physician; morning Sickness; or like conditions that are not medically termed as Complications of Pregnancy.

Cosmetic means any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury.

Covered Expense(s) means a Usual and Customary fee for a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or Covered Person's health, which is eligible for coverage in this Plan. Covered Expenses will be determined based upon all other Plan provisions.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in this document.

Covered Person means an Employee, Retired Employee or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual insurance policy, Medicaid, Medicare, and a State Children's Health Insurance Program (SCHIP). Creditable Coverage also includes coverage under a public health plan of a State, city, county or other government subdivision, or of the U.S. or of any foreign country. Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Custodial Care means care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding or supervision over medication that could normally be self-administered.

Dentist means a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent means one or more of the following person(s):

1. an Employee's lawfully married spouse possessing a marriage license who is not divorced from the Employee;

2. an Employee's Child who is less than 26 years of age; or

3. an Employee's Child, regardless of age, who was continuously covered prior to attaining the limiting age as stated in the numbers above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age as stated in the numbers above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 60 days after the date the Child attains the limiting age as stated in the numbers above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.

“Dependent” does not include any person who is a member of the armed forces of any country or who is a resident of a country outside the United States.

The Plan Administrator has discretionary authority to interpret these terms, and determine spousal status as defined herein, to the extent allowed by law.

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

Durable Medical Equipment means equipment which a) can withstand repeated use, b) is primarily and customarily used to serve a medical purpose, c) generally is not useful to a person in the absence of an Illness or Injury and d) is appropriate for use in the home.

Emergency Medical Condition means 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 one of the following outcomes: (i) 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; or (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

Emergency Services mean, with respect to an Emergency Medical Condition:

1. 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

2. 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 means a person who is an active, regular Employee of the Employer regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer means **Wa-Nee Community Schools**

Enrollment Date means the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Experimental and/or Investigational means any drugs, devices, procedures or treatments such that:

1. its use requires approval by the appropriate federal or other governmental agency which has not been granted, such as, but not limited to, the Federal Drug Administration (FDA); or

2. its use is not yet recognized as acceptable medical practice throughout the United States to treat that Illness or Injury, or is subject to either:

    a. a written investigational or research protocol; or

    b. a written informed consent or protocol used by the treating facility in which reference is made to the drug, device, procedure or treatment as being experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or

    c. A written protocol, protocols or informed consent used by any other facility studying substantially the same drug, device, procedure or treatment which states it is experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or

    d. An ongoing review by an Institutional Review Board (IRB); or

3. It does not have either:

a. the positive endorsement of national medical bodies or panels, such as the American Cancer Society, the Agency for Health Care Policy and Research, or the National Cancer Institute; or

b. multiple published peer review articles, in a recognized professional medical journal, concerning such drug, device, procedure or treatment and reflecting its reproducibility by non-affiliated sources which the Company determines to be authoritative; or

c. trial results which indicate the drug, device, procedure or treatment are at least as effective as the current standard therapy.

Any drug, device, procedure or treatment which is deemed to be experimental or investigational in nature by an appropriate technological body established by state or federal government is considered an experimental procedure.

Routine patient costs associated with an Approved Clinical Trial are deemed not to be Experimental or Investigational.

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

Family Unit means the covered Employee or Retired Employee and the family members who are covered as Dependents under the Plan.

Formulary Drug means a federal legend drug that has been determined by the PBM's Physicians & Therapeutics Committee to be generally lower in cost compared to other federal legend brand drugs in the same therapeutic class.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Foster Child means an unmarried Child under the limiting age shown in the "Dependent Eligibility" section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: a) the Child is being raised as the covered Employee's; b) the Child depends on the covered Employee for primary support; c) the Child lives in the home of the covered Employee; and d) the covered Employee may legally claim the Child as a federal income tax deduction.

A covered Foster Child is **not**: a) a Child temporarily living in the covered Employee's home; b) placed in the covered Employee's home by a social service agency which retains control of the Child; or c) whose natural parent(s) may exercise or share parental responsibility and control.

Generic Drug means a Prescription Drug that has the equivalency of the brand name drug with the same use and metabolic disintegration.

Genetic Information means information about genes, gene products and inherited characteristics that may be derived 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.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care Agency is an organization that meets all of these tests: a) its main function is to provide Home Health Care Services and Supplies; b) it is federally certified as a Home Health Care Agency; and c) it is licensed by the state in which it is located, if licensing is required.

Home Health Care Services and Supplies include: a) part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); b) part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); c) physical, occupational and speech therapy; d) medical supplies; and e) laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and is licensed by the state in which it is located, if licensing is required.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital unit that provides treatment under a Hospice Care Plan and admits at least two (2) unrelated persons who are expected to die within six (6) months.

Hospital is an institution that meets all of the following requirements:

A) it is accredited as a hospital under the Hospital Accreditation Program of The Joint Commission (TJC), it is legally operated, has 24-hour a day supervision by a staff of Physicians, has 24-hour a day nursing service by registered graduate nurses, and complies with (i) or (ii):

(i) It mainly provides general inpatient medical care and treatment of sick and injured persons by the use of medical, diagnostic, and major surgical facilities. All such facilities are in it, or under its control; or

(ii) It mainly provides specialized inpatient medical care and treatment of sick and injured persons by the use of medical and diagnostic facilities (including x-ray and laboratory). All such facilities are in it, under its control, or available to it under a written agreement with a Hospital or with a specialized provider of these facilities; or

B) it is an institution that provides care and treatment of mental, psychoneurotic, and personality disorders, or alcoholism or drug abuse through one or more specialized programs, and meets all of these tests:

(i) It is staffed by registered graduate nurses and other mental health professionals;

(ii) It provides for the clinical supervision of such specialized programs by Physicians who are licensed in the state in which it is located;

(iii) Each specialized program provided by it must:

a) Provide treatment for no less than three hours, nor more than 12 hours per day; and

b) Furnish a written individual treatment plan which states specific goals and objectives; and

c) Maintain at a minimum, ongoing weekly progress notes that demonstrate periodic review and direct patient evaluation by the attending Physician; and

d) Meet either of these two tests:

(I) It is accredited by The Joint Commission (TJC) to provide the type of specialized program described above; or

(II) It is licensed, accredited, or approved by the appropriate agency in the state in which it is located to provide the type of specialized program described above.

which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient’s expense and which fully meets these tests: a) it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; b) it is approved by Medicare as a Hospital; c) it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; d) it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of register nurses (R.N.s); and e) it is operated continuously with organized facilities for operative surgery on the premises.

The definition of “Hospital” shall be expanded to include the following facilities as hospitals:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: a) maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; b) has a Physician in regular attendance; c) continuously provides 24-hour-a-day nursing service by a registered nurse (R.N.); d) has a full-time psychiatrist or psychologist on the staff; and e) is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical Sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or Complications of Pregnancy.

Incurred means that Covered Charges are 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 Charges 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 Charges 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 means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area that is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a “coronary care unit” or an “acute care unit”. It has facilities for special nursing care not available in regular rooms and wards of the Hospital, special life saving equipment which is immediately available at all times, at least two beds for the accommodation of the critically ill, and at least one registered nurse (R.N.) in continuous and constant attendance 24-hours a day.

Late Enrollee means an eligible Employee who does not enroll under the Plan when first eligible, or within 31 days of loss of other coverage that qualifies as a Special Enrollment event under the Plan. The term Late Enrollee includes those eligible Dependents who are not enrolled by the eligible Employee within 31 days of a Special Enrollment event, as required under Plan terms.

Leave of Absence means a Leave of Absence of an Employee that has been approved by his or her Participating Employer, as provided for in the Participating Employer’s rules, policies, procedures and practices.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor Child.

Legal Separation means an arrangement to remain married but live apart, following a court order.

Maximum Amount and/or Maximum Allowable Charge means the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) may be the lesser of:

1. the Usual and Customary amount;
2. the Allowable Charge specified under the terms of the Plan;
3. the Reasonable charge specified under the terms of the Plan;
4. the negotiated rate established in a contractual arrangement with a Provider; or
5. the actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Maximum Lifetime Benefit means that this Plan has an unlimited Maximum Lifetime Benefit Amount.

Medical Care Facility means a Hospital or a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medically Necessary means care and treatment that: a) is recommended or approved by a Physician or Dentist; b) is consistent with the patient's condition or accepted standards of good medical and dental practice; c) is medically proven to be an effective treatment of the condition; d) is not performed mainly for the convenience of the patient or provider; e) is not conducted for research purposes; and f) is the most appropriate level of services which can be safely provided to the patient.

The fact that any particular provider individual may prescribe, order, recommend, or approve a service, supply or level of care does not, of itself, make such treatment Medically Necessary or make the charge a Covered Charge.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means 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.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most current actuarial tables for a person of the same height, age and mobility as the Covered Person.

Naprapathic Care Services relates to all care and treatment rendered by a Doctor of Naprapathy*; Naprapathy is a branch of medicine (manual medicine) that focuses on the evaluation and treatment of neuro-musculoskeletal conditions. Naprapathic treatment consists of naprapathic manipulative techniques, adjunctive (additional) treatments, and nutritional counseling. **Doctors of Naprapathy (D.N.) (naprapathic Physicians) are not Doctors of Medicine (M.D.) (allopathic Physicians), an important distinction.*

No-Fault Auto Insurance is the basic reparation provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Formulary Drug means a federal legend drug that has been determined by the PBM's Physicians and Therapeutics Committee to be expensive in price compared to other federal legend drugs in the same therapeutic class.

Other Plan includes, but is not limited to:

1. any primary payer besides the Plan;
2. any other group health plan;
3. any other coverage or policy covering the Covered Person;
4. any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. any policy of insurance from any insurance company or guarantor of a responsible party;
6. any policy of insurance from any insurance company or guarantor of a third party;
7. workers' compensation or other liability insurance company; or
8. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Outpatient Care is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or x-ray facility, an Ambulatory Surgical Center, or the patient's home.

Partial Hospitalization is 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 24 hours, but more than four hours a day and no charge is made for room and board.

Period of Confinement: Two (2) or more confinements are treated as follows:

1. if they are due to unrelated causes, they are treated as separate periods of confinement;
2. if they are due to related causes, they are treated as separate periods of confinement if:
    a) for an Employee, they are separated by return to active work; or
    b) in the case of a Dependent, they are separated by at least three (3) months in a row.
3. if due to related causes, they are treated as one period of confinement when not separated as shown in (2) above.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws for the state where he or she practices.

PHSA means the Public Health Service Act, a federal statute.

Physician means Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Licensed Clinical Social Worker (L.C.S.W.), Speech Language Pathologist and any other practitioner of the Healing Arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means **Wa-Nee Community Schools Health Care Plan**, which is a benefit plan for eligible Employees and Retired Employees of **Wa-Nee Community Schools** and is described in this Plan Document.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year that is a short Plan Year.

Pre-Admission Testing Services covers diagnostic lab tests and x-ray exams when:

1. performed on an outpatient basis within seven (7) days before a Hospital confinement;
2. related to the condition which causes the confinement; and
3. performed in place of tests while Hospital confined.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications*.

Prescription Drug means any of the following: a) 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"; b) injectable insulin; and/or c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such a drug must be Medically Necessary in the treatment of a Sickness or Injury.

Qualified Medical Child Support Orders are a judgment or decree by a court of "competent jurisdiction" that requires a group health plan to provide coverage to the Dependent Children of a Covered Employee pursuant to a state domestic relations law, or an administrative order in the form of a National Medical Child Support Order issued by a State agency. A person who is an alternate recipient under a Qualified Medical Child Support Order shall be considered a beneficiary under the Plan for purposes of the Act. "Alternate Recipient" means any Child of a Covered Employee who is recognized under a medical Child support order as having a right to enrollment under a group health

plan with respect to such Covered Person. A Covered Employee may obtain without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator.

Reasonable means in the 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 Administrator, 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 Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. 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.

Retired Employee, where a Plan specifically provides for retiree coverage, is a former Active Employee of the Employer who meets the definition of a Retiree adopted by the Employer as set forth under the Plan document, and who elects coverage subject to payment of the required retiree contribution.

Routine Patient Costs – Clinical Trial includes items and services typically provided under the plan for a participant not enrolled in a clinical trial. However, such items and services do not include (a) the investigational item, device or service itself; (b) items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or (c) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

Standard of care drugs once mixed with experimental drugs, are deemed no longer to be standard of care, and therefore experimental and not covered by the Plan. Should a regulation or interpretation under ACA contradict this interpretation, the Plan shall automatically be amended to comply with such interpretation.

Sickness is: Illness, disease or Pregnancy.

Skilled Nursing Facility is a facility that fully meets all of these tests:

1. it is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided;

2. its services are provided for compensation and under the full-time supervision of a Physician;

3. it provides 24-hour per day nursing services by a licensed nurse, under the direction of a full-time registered nurse (R.N.);

4. it maintains a complete medical record on each patient;
5. it has an effective utilization review plan;
6. it is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, intellectual and developmental disabilities, Custodial or educational care or care of Mental Disorders; and
7. it is approved and licensed by Medicare.

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation Hospital or any other similar nomenclature.

Substance Abuse/Chemical Dependency means 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 Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as follows:

1. 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 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. Craving or a strong desire or urge to use a substance; 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);
2. The symptoms have never met the criteria for substance dependence for this class of substance.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means:

- In the case of an Active Employee:

  The complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness. The Plan Administrator will determine Total Disability.

- In the case of a Dependent:

  The complete inability to perform the normal activities of a person of like age and sex in good health as a result of Injury or Sickness.

Usual and Customary means Covered Expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges (or accepts for) 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, and the Medicare reimbursement rates. 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 or accepted 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 was 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 an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Covered Person by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Women's Health and Cancer Rights Act of 1998 provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy (including lymphedema).

PLAN EXCLUSIONS

Note: *Exclusions related to Prescription Drugs are on file with the Pharmacy Benefit Manager (PBM).*

For all medical benefits shown in the Schedule of Benefits, a charge for the following is **not** covered:

1. **Abortion** – Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.

2. **Claim Forms** – Fees Incurred for completing claims forms.

3. **Cosmetic Procedures** – Charges Incurred in connection with the care or treatment of, or operations that are performed for Cosmetic purposes, except to correct a congenital anomaly, reconstructive breast surgery if a mastectomy has been performed, or for Injuries sustained in an accident.

4. **Custodial Care** – Services or supplies provided mainly as a rest cure, maintenance or Custodial Care, except as shown in the Schedule of Benefits.

5. **Dental** – dental treatment, except as specifically provided in the Plan.

6. **Educational or Training Programs** – Services performed by a Physician or other provider enrolled in an educational or training program when such services are related to that program, except as specifically provided in the Plan.

7. **Educational or Vocational Testing** – Services for educational or vocational testing or training, except as shown in the Schedule of Benefits.

8. **Error** – Expenses required to treat Injuries that are sustained or an Illness that is contracted, including infections and complications, while the Covered Person was under, and due to, the care of a Provider wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense.

9. **Excess Charges** – That are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document..

10. **Exercise Programs** – Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, and occupational or physical therapy covered by this Plan.

11. **Experimental or Investigational** – Care and treatment that is either Experimental or Investigational.

12. **Eye Care** – Radial keratotomy or other eye surgery to correct near-sightedness. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages, except as shown in the Schedule of Benefits.

13. **Foot Care** – All treatment of the feet (except open cutting operations and treatment required due to metabolic or peripheral vascular disease), except as shown in the Schedule of Benefits.

14. **Foreign Travel** – Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services, unless approved by medical management.

15. **Genetic Testing and Counseling** – Charges related to genetic testing or counseling, except as shown in the Schedule of Benefits. Genetic manipulation, including testing, shall be

covered to the extent it is considered necessary treatment for purposes of diagnosing a disease or determining the course of treatment.

16. **Government Coverage** – Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

17. **Hair Loss** – Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy.

18. **Hearing Aids and Exams** – Charges for services or supplies in connection with hearing aids or exams for their fitting unless required as a result of a surgical procedure performed while covered under the Plan, except as shown in the Schedule of Benefits.

19. **Home Birth** – Charges Incurred in a non Hospital or Birthing Center environment; charges for services or supplies in connection with home birthing.

20. **Hospital Employees** – Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

21. **Hygiene** – Services, supplies, care or treatment to a Covered Person for hygienic purposes, except as shown in the Schedule of Benefits.

22. **Illegal Acts** – Charges for services received as a result of Injuries sustained, or Sickness contracted, while the Covered Person: a) was engaged in an illegal act or occupation; b) committed or attempted to commit any crime, criminal act, assault or other felonious behavior; or c) participated in a riot or public disturbance. This exclusion does not apply to alcohol. This exclusion does not apply if the Injury resulted from an act of domestic violence or a documented medical (including both physical and mental health) condition.

23. **Illegal Drugs or Medications** – Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of, or being under the influence of, any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances, and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

24. **Immediate Family Member** – Services rendered by a member of the immediate Family Unit or person residing in the same household.

25. **Incurred by Other Persons** – Expenses actually Incurred by other persons;

26. **Infertility, Reproductive Enhancement, Genetic Manipulation** – Charges related to or in connection with fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, in-vitro fertilization and other related procedures, except as shown in the Schedule of Benefits.

27. **Medically Necessary** – Care and treatment that is not Medically Necessary.

28. **Missed Appointments** – Charges Incurred in the event of a missed appointment.

29. **Negligence** – Expenses for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.

30. **No Charge** – Care and treatment for which there would not have been a charge if no coverage had been in force.

31. **No Obligation to Pay** – Charges Incurred for which the Plan has no legal obligation to pay.

32. **No Physician Recommendation** – Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the Regular Care of a Physician. "Regular Care" means ongoing medical supervision or treatment that is appropriate care for the Injury or Sickness.

33. **Obesity** – Treatment for obesity including any Surgery for morbid obesity or for removal of excess fat or skin following weight loss, regardless of Medical Necessity unless a covered employee or dependent is eligible for the BariNet program. See guidelines outlined in COVERED CHARGES, Bariatric Surgery.

34. **Occupational** – Care and treatment of an Injury or Sickness that is occupational; that arises from work for wage or profit including self-employment, if covered by workers' compensation.

35. **Personal Comfort Items** – Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-Prescription Drugs and medicines, first-aid supplies and non-hospital adjustable beds.

36. **Plan Design Excludes** – Charges excluded by the Plan as set forth in this Plan Document.

37. **Prescription Drugs** – Charges for outpatient drugs not purchased through the Prescription Drug card vendor (if applicable) or coordinated by Case Management.

38. **Provider Error** – Services required as a result of unreasonable Provider error.

39. **Replacement of Braces** – Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

40. **Sales Tax** – Charges for sales tax.

41. **Self-Inflicted** – Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a documented medical (including both physical and mental health) condition.

42. **Services Before or After Coverage** – Care, treatment or supplies for which a charge was Incurred before a person was covered under this Plan or after coverage ceased under this Plan.

43. **Sex Changes** – Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery and medical or psychiatric treatment.

44. **Shipping and Handling** – Charges for shipping and handling.

45. **Sleep Disorders** – Care and treatment for sleep disorders unless deemed Medically Necessary.

46. **Smoking Cessation** – Care and treatment for smoking cessation programs unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.

47. **Subrogation, Reimbursement, and/or Third Party Responsibility** – Expenses of an Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

48. **Surgical Sterilization Reversal** – Care and treatment for reversal of surgical sterilization.

49. **Teeth** – Charges Incurred for treatment on or to the teeth, the nerves or toots of the teeth, gingival tissue or alveolar processes; however, benefits will be payable for Hospital and doctor charges Incurred (a) for such work or treatment done while the person is confined in a Hospital for at least 23 hours; in the case of oral dental surgery, such confinement must be ordered by a doctor because the life or health of the person will be placed in danger if such surgery is

done while person is not confined to a Hospital. Oral dental surgery is limited to charges for cutting procedures for diseases or the extraction of impacted teeth; and (b) for treatment required because of accidental bodily Injury to natural teeth sustained while covered. Section (b) of this exception shall not in any event be deemed to include charges for treatment of the repair or replacement of a denture.

50. **Telephone Consultations** – Charges incurred for consultations by telephone.

51. **Travel or Accommodations** – Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.

52. **Vitamins** – Charges for vitamins and nutritional supplements whether or not a Physician's Prescription is required.

53. **War** – Any loss that is due to a declared or undeclared act of war. This exclusion does not apply to any Covered Person who is not a member of the armed forces.

PRESCRIPTION DRUG CARD BENEFITS

PRESCRIPTION DRUG COVERAGE

Prescription Drugs may be covered under this Plan in two ways:

1. under the prescription drug card benefit; or
2. under the medical provisions of the Plan; as authorized.

PHARMACY DRUG CHARGE

Participating Pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Please refer to the Employee ID card for the prescription drug card vendor.

MAIL ORDER DRUG BENEFIT OPTION

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

CO-PAYMENT

The co-payment is applied to each covered mail order prescription charge and is shown in the Schedule of Benefits. It is not a Covered Charge under the Medical Plan.

COVERED PRESCRIPTION DRUGS

1. All drugs prescribed by a Physician that require a prescription either by federal or state law, unless otherwise excluded.
2. Certain drugs are covered through the Pharmacy drug plan and others are covered under the Medical Plan.
3. *Claritin OTC* (Over-the-Counter), subject to any applicable Pharmacy benefit deductible or co-payment.
4. *Prilosec OTC* (Over-the-Counter), subject to any applicable Pharmacy benefit deductible or co-payment.

LIMITS TO THIS BENEFIT

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

1. refills only up to the number of times specified by a Physician; and
2. refills up to one year from the date of order by a Physician.

EXPENSES NOT COVERED

This benefit will not cover a charge for any of the following unless noted otherwise. Please consult with the drug card vendor for a complete listing of Plan limitations.

1. **Administration** – Any charge for the administration of a covered Prescription Drug.
2. **Appetite Suppressants** – A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

3. **Birth Control** that is either injectable or implantable.

4. **Consumed on Premises** – Any drug or medicine that is consumed or administered at the place where it is dispensed.

5. **Devices** – Devices of any type, even though they may require a prescription, including but not limited to therapeutic devices, artificial appliances, braces, support garments or any similar device.

6. **Experimental Drugs** and medicines, even though a charge is made to the Covered Person.

7. **FDA** – Any drug not approved by the Food and Drug Administration.

8. **Investigational** – A drug or medicine labeled, “Caution – limited by federal law to Investigational use”.

9. **No Charge** – A charge for Prescription Drugs that properly may be received without charge under local, state or federal programs.

10. **No Prescription** – A drug or medicine that legally can be bought without a written prescription. This does not apply to injectable insulin.

11. **Refills** – Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

12. **Sexual Dysfunction** – A drug or medicine that improves or enhances sexual function.

13. **Smoking Cessation Products** – Any products used to help patients stop smoking.

HOW TO SUBMIT A CLAIM AND CLAIM APPEAL PROCEDURES

The procedures outlined below must be followed by Covered Persons ("claimants") to obtain payment of health benefits under this Plan. "Health benefits" includes *medical and prescription drug claims.*

When a Covered Person has a claim to submit for payment, that person must:

1. Obtain a claim form from the Personnel Office or the Plan Administrator.
2. Complete the Employee portion of the form. ***All questions <u>must</u> be answered.***
3. Have the Physician or Dentist complete the provider's portion of the form.
4. For Plan reimbursements, attach bills for services rendered. ***All bills <u>must</u> show the following information:***
   a) Name of Plan;
   b) Employee's name;
   c) Name of patient;
   d) Name, address, telephone number of the provider of care;
   e) Diagnosis;
   f) Type of services rendered, with diagnosis and/or procedure codes;
   g) Date of services; and
   h) Charges.
5. Send the above to the Claims Administrator at this address:

Group Administrators, Ltd.
915 National Parkway, Suite F
Schaumburg, Illinois 60173
847-519-1880

All claims and questions regarding health claims should be directed to the Claims Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Plan Document and Summary Plan Description may be delegated to the Claims Administrator; provided, however, that the Claims Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the claimant has not incurred a Covered Expense or that the benefit is not covered under the Plan, or if the claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

<u>Under the Plan, there are *four* types of claims</u>: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

<u>Pre-service Claims</u>:

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.

A "Pre-service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if a claimant needs medical care for a condition which could seriously jeopardize his or her life, there is no need to contact the Plan for prior approval. The claimant should obtain such care without delay.

Further, if the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

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 (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the claimant requests extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Post-service Claims:

A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

WHEN HEALTH CLAIMS MUST BE FILED

Health claims must be filed with the Claims Administrator within 90 days of the date charges for the service were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Charges are considered Incurred when treatment or care is given or supplies are provided. **Claims filed later than that date may be declined or reduced unless:**

1. It is not reasonably possible to submit the claim within 90 days of the date charges for the services are Incurred; and

2. The claim is submitted by December 31st of the Calendar Year following the year the pertinent charges were Incurred. This limitation will not apply when the Plan Participant is not legally capable of submitting the claim.

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 Claims Administrator in accordance with the Plan's procedures. However, a Post-service Claim is considered to be filed when the following information is received by the Claims Administrator, together with a Form HCFA or Form UB92:

1. The date of service;

2. The name, address, telephone number and tax identification number of the provider of the services or supplies;

3. The place where the services were rendered;

4. The diagnosis and procedure codes;
5. The amount of charges;
6. The name of the Plan;
7. The name of the covered Employee; and
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days (48 hours in the case of Pre-service Urgent Care Claims) from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

TIMING OF CLAIM DECISIONS

The Plan Administrator shall notify the claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-service Urgent Care Claims:

If the claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 72 hours after receipt of the claim. The claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the claimant to provide the information.

Pre-service Non-urgent Care Claims:

If the claimant 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 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The claimant 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 Administrator and the claimant (if additional information was requested during the extension period).

Concurrent Claims:

Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the claimant 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 claimant will be notified sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a claimant 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 24 hours after receipt of the claim, as long as the claimant makes the request at least 24

hours prior to the expiration of the prescribed period of time or number of treatments. If the claimant submits the request with less than 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 Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the claimant 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).

Post-service Claims:

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

If the claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the claimant 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 claimant will be notified of the determination by a date agreed to by the Plan Administrator and the claimant.

Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service Urgent Care Claims.

Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

- **Notification of an Adverse Benefit Determination**

The Plan Administrator shall provide a claimant 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 following within 3 days), containing the following information:

1. A reference to the specific portion(s) of the Plan Document and Summary Plan Description upon which a denial is based;

2. Specific reason(s) for a denial;

3. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;

4. A description of the Plan's review procedures and the time limits applicable to the procedures.

5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;

6. 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);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request);
8. 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 claimant's medical circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request; and
9. In a claim involving Urgent Care, a description of the Plan's expedited review process.

APPEALS 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 claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination and 60 days to appeal a second Adverse Benefit Determination;
2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. 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;
4. For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
5. 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;
6. 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;
7. That a claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits in the possession of the Plan Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances; and
8. In an Urgent Care Claim, for an expedited review process pursuant to which:

A request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the claimant; and

All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

FIRST APPEAL LEVEL

- **Requirements for First Appeal**

The claimant must file the first appeal in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) within 180 days following receipt of the notice of an Adverse Benefit Determination. For Pre-service Urgent Care Claims, if the claimant chooses to orally appeal, the claimant may telephone 847-519-1880 and ask for the Claim Manager. To file an appeal in writing, the claimant's appeal must be addressed as follows and faxed to the following number:

Group Administrators, Ltd.
915 National Parkway, Suite F
Schaumburg, Illinois 60173
Attention: Claim Manager
Phone: 847-519-1880
Fax: 847-519-1979

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

1. The name of the Employee/claimant;
2. The Employee/claimant's identification number;
3. The group name or identification number;
4. 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. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal**;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

If the claimant 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 First Appeal**

The Plan Administrator shall notify the claimant of the Plan's benefit determination on review within the following timeframes:

<u>Pre-service Urgent Care Claims</u>: As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the appeal.

<u>Pre-service Non-urgent Care Claims</u>: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.

<u>Concurrent Claims</u>: The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.

<u>Post-service Claims</u>: Within a reasonable period of time, but not later than 30 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.

- **Manner and Content of Notification of Adverse Benefit Determination on First Appeal**

The Plan Administrator shall provide a claimant 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:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Plan Document on which the denial is based;
3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
6. If the Adverse Benefit Determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge upon request;
7. A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain information regarding any such procedures;
8. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
9. A description of the Plan's review procedures and the time limits applicable to the procedures; and
10. For Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claims.

- **Furnishing Documents in the Event of an Adverse Determination**

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 7 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

SECOND APPEAL LEVEL

Adverse Decision on First Appeal; Requirements for Second Appeal In cases where a claim for benefits is denied, in whole or in part, the Participant may appeal the denial. If a Participant would like to appeal a denial, the Participant must submit a written request appealing the denial, within 60 days of receipt of the denial to:

Wa-Nee Community Schools
1300 N. Main Street
Nappanee, Indiana 46550
Phone: 574-773-3131
Fax: 574-773-5593

The appeal request must be written and include:

1. The name and identification number of the Employee, the name of the patient, and the Plan or group identification number, if any; and

2. A clear and concise statement of the specific reason or reasons for the disagreement with the handling of the claim, and why the claim should not be denied, in whole or in part, including specific references to Plan provisions supporting the claim.

Appeals raising issues related to coverage, coverage discrimination, and access under the Plan will be decided by a review panel. Upon receipt of an appeal, the review panel will promptly convene to review the appeal, and will normally make its decision within 90 days after its first meeting discussing the appeal. If additional time or more information is needed to review the appeal, the review panel will notify the Participant.

COORDINATION OF BENEFITS

Coordination of the Benefit Plans – Coordination of benefits sets out rules for the order of payment of Covered Charges when a Covered Person (or his Spouse or covered Children) is covered by this Plan and another Benefit Plan. In that event, the Benefit Plans will coordinate benefits when a claim is received.

The Benefit Plan that pays first according to the rules will pay as if there were no other Benefit Plan involved. The secondary and subsequent Benefit Plan(s) will pay the balance due up to 100% of the total Allowable Charges.

Benefit Plan – This provision will coordinate the medical benefits of Benefit Plans. The term "Benefit Plan" means this Plan and any one of the following plans:

1. group or group-type plans, including franchise and blanket benefit plans;
2. Blue Cross and Blue Shield group plans;
3. group practice and other group pre-payment plans;
4. Federal government plans and programs, including Medicare;
5. other plans required or provided by law, but not including Medicaid or any similar benefit plan that, by its terms, does not allow coordination;
6. No-Fault Auto Insurance, by whatever name it is called, when not prohibited by law; and
7. individual or personal plans and policies.

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.

The Plan's benefits will be excess to, whenever possible:

1. any primary payer besides the Plan;
2. any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. any policy of insurance from any insurance company or guarantor of a third party;
4. workers' compensation or other liability insurance company; or
5. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Allowable Charge – For a charge to be allowable, it must be a Reasonable, Usual and Customary Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only Benefit Plans, this Plan will not consider any charges in excess of what an HMO or Network Provider has agreed to accept as payment in full. Also, when an HMO or network Benefit Plan is primary and the Covered Person does not use an HMO or Network Provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network Benefit Plan had the Covered Person used the services of an HMO or Network Provider.

In the case of service-type Benefit Plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile Limitations – When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall

always be considered the secondary carrier regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier.

Benefit Plan Payment Order – When two or more Benefit Plans provide benefits for the same Allowable Charge, benefit payment will follow these rules.

1. Benefit Plans that do not have a coordination provision, or one like it, will pay first. Benefit Plans with such a provision will be considered after those without one.

2. Benefit Plans with a coordination provision will pay their benefits up to the Allowable Charge.

   a) The benefits of the Benefit Plan that covers directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the Benefit Plan that covers the person as a Dependent ("Plan B"). Special Rule, if:

      (i) the person covered directly is a Medicare beneficiary; and

      (ii) Medicare is secondary to Plan B; and

      (iii) Medicare is primary to Plan A (for example, if the person is retired); **then**

      Plan B will pay before Plan A.

   b) The benefits of a Benefit Plan which covers a person as an employee who is neither laid-off nor retired are determined before those of a Benefit Plan which covers that person as a laid-off or Retired Employee. The benefits of a Benefit Plan which covers a person as a Dependent of an employee who is neither laid-off nor retired are determined before those of a Benefit Plan which covers a person as a Dependent of a laid-off or Retired Employee. If the other Benefit Plan does not have this rule, and if, as a result, the Benefit Plans do not agree on the order of benefits, this rule does not apply.

   c) The benefits of a Benefit Plan which covers a person as an employee who is neither laid-off nor retired or a Dependent of an employee who is neither laid-off nor retired are determined before those of a Benefit Plan which covers the person as a COBRA beneficiary.

   d) When a Child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

      (i) the benefits of the Benefit Plan of the parent whose birthday falls earlier in a year are determined before those of the Benefit Plan of the parent whose birthday falls later in that year; or

      (ii) if both parents have the same birthday, the benefits of the Benefit Plan that has covered the parent for the longer time are determined before those of the Benefit Plan which covers the other parent.

   e) When a Child's parents are divorced or legally separated, these rules will apply:

      (i) This rule applies when the parent with custody of the Child has not remarried. The Benefit Plan of the parent with custody will be considered before the Benefit Plan of the parent without custody.

      (ii) This rule applies when the parent with custody of the Child has remarried. The Benefit Plan of the parent with custody will be considered first. The Benefit Plan of the stepparent that covers the Child as a Dependent will be considered next. The Benefit Plan of the parent without custody will be considered last.

      (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the Child. In this case, the Benefit Plan of that parent will be considered before other Benefit Plans that cover the Child as a Dependent.

(iv) If the specific items of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the Child, the Benefit Plans covering the Child shall follow the order of benefit determination rules outlined above when a Child is covered as a Dependent and the parents are not separated or divorced.

f) If there is still a conflict after these rules have been applied, the Benefit Plan which has covered the parent for the longer time will be considered first. When there is a conflict in coordination of benefit rules, this Plan will never pay more than 50% of Allowable Charges when paying secondary.

3. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

4. 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.

Claims Determination Period – Benefits will be coordinated on a Calendar Year basis. This is called the "Claims Determination Period."

Right to Receive or Release Necessary Information – To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about the other plans and their payment of Allowable Charges.

Facility of Payment – This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of Recovery – This Plan may pay benefits that should be paid by another Benefit Plan. In this case, this Plan may recover the amount paid from the other Benefit Plan or the Covered Person. That repayment will count as a valid payment under the other Benefit Plan. Further, this Plan may pay benefits that are later found greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Benefits Subject to This Provision – This provision shall apply to all benefits provided under any section of this Plan.

When This Provision Applies – A Covered Person may incur medical or other charges related to Injuries or Illness for which benefits are paid by the Plan. The Injuries or Illness may be caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of any charges Incurred in connection with the Injuries or Illness. If so, the Covered Person may have a claim against that other person or a third party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be subrogated to all rights the Covered Person may have against that other person or third party and will be entitled to Reimbursement. In addition, the Plan shall have a first priority lien against any Recovery to the extent of benefits paid or to be paid and expenses Incurred by the Plan in enforcing this provision. The Covered Person agrees that acceptance of benefits under the Plan is constructive notice of this provision.

As a condition to receiving benefits under the Plan, the Covered Person must:

1. assign and subrogate to the Plan his rights to recovery when this provision applies;
2. authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses Incurred by the Plan in collecting this amount;
3. immediately reimburse the Plan out of the Recovery made from the other person, the other person's insurer or the third party, 100% of the amount of medical or other benefits paid for the Injuries under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);
4. notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
5. cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a right of recovery exists, the Covered Person and his attorney will execute and deliver all required instruments and papers, including a subrogation agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injuries or Illness. The Plan has no obligation to pay any medical or other benefits for the Injuries or Illness before these papers are signed and things are done; however, in the event the Plan does so, the Plan will still be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing, and will not permit his attorney to do anything, to prejudice the right of the Plan to subrogate and be reimbursed and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines. If the Covered Person retains an attorney, the Covered Person agrees to only retain one who will not assert the common-fund or made-whole doctrines. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

Amount Subject to Subrogation or Reimbursement – **All amounts recovered will be subject to Subrogation or Reimbursement.** In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in

full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his charges and expenses.

"Another Party" shall mean any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's Injuries or Illness.

"Another Party" shall include the party or parties who caused the Injuries or Illness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Illness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, No-Fault Auto Insurance, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the Injuries or Illness.

"Recovery" shall mean any and all monies paid to the Covered Person by way of judgment, settlement, or otherwise (and no matter how those monies may be characterized or designated) to compensate for all losses caused by, or in connection with, the Injuries or Illness. Any Recovery shall be deemed to apply, first, for Reimbursement.

"Subrogation" shall mean the Plan's right to pursue the Covered Person's claims for medical or other charges paid by the Plan against the other person, the other person's insurer and the third party.

"Reimbursement" shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the Injury or Illness and for the expenses incurred by the Plan in collecting this benefit amount.

RIGHT OF REIMBURSEMENT

1. 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 Covered Person(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 lien and right to reimbursement. The obligation to reimburse the Plan in full 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 Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. 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.

3. 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 Covered Person(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.

4. 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 Covered Person(s).

5. 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.

Separation of Funds – Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(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.

When the Covered Person is a Minor – These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery:

1. In the event the Covered Person(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.

When a Covered Person Does Not Comply – When a Covered Person does not comply with the provisions of this Section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to reduce future benefits payable under the Plan by the amount due as Reimbursement to the Plan. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Wrongful Death – In the event that the Covered Person(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 Covered Person(s) and all others that benefit from such payment.

Offset – If timely repayment is not made, or the Covered Person and/or his/her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan.

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.

COBRA CONTINUATION OPTIONS

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

This Plan Section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you or they would otherwise lose Plan coverage. You, your enrolled spouse or enrolled Dependents will be required to pay for COBRA continuation coverage. This information is included as part of the Summary Plan Description/Plan document. For additional information, you should contact the Plan Administrator.

The Plan Administrator is **Wa-Nee Community Schools, 1300 N. Main Street, Nappanee, Indiana 46550**. COBRA continuation coverage for the Plan is administered by a COBRA Administrator designated by the Plan Administrator. The name of the COBRA Administrator can be found in the ERISA General Information Section at the end of this Plan Document/Summary Plan Description.

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is listed as a "qualified beneficiary." A qualified beneficiary is an enrolled individual (you, your spouse, and your Dependent Child) who will lose coverage under the Plan because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage (the full cost means the employee and employer cost of coverage).

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes entitled to Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse. In the event your spouse, who is the employee, reduces or terminates your coverage under the Plan in anticipation of a divorce or legal separation which later occurs, the divorce or legal separation may be considered a qualifying event even though the coverage was reduced or terminated before the divorce or separation.

Your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;

3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The Child stops being eligible for coverage under the plan as a "Dependent Child".

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event, but only if the Plan offers retiree coverage. If a proceeding in bankruptcy is filed with respect to the Plan Administrator, and that bankruptcy results in the loss of retiree coverage, if available under the Plan, the Retired Employee becomes a qualified beneficiary with respect to the bankruptcy. The covered spouse and covered Dependent Children of the covered retiree also will be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the covered employee, commencement of a proceeding in bankruptcy with respect to the employer, or entitlement of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (including divorce or legal separation of the employee and spouse, or a Dependent Child's losing eligibility for coverage as a Dependent Child, the occurrence of a second qualifying event, or a change in disability status), you must notify the Plan Administrator. You or your spouse must send this written notice to: **Wa-Nee Community Schools, 1300 N. Main Street, Nappanee, Indiana 46550**. Your written notice should include the date of the qualifying event. If you or your spouse are notifying the Plan Administrator of a divorce or legal separation, you or your spouse should provide a copy of the legal separation papers or divorce decree. This notice must be furnished within 60 days of the latest of:

1. the date upon which the qualifying event occurs;
2. the date upon which the qualified beneficiary loses (or would lose) Plan coverage due to a Qualifying Event; or
3. the date upon which the Qualified Beneficiary is notified via the Plan's SPD or general notice, and/or becomes aware of their status as a Qualified Beneficiary and/or the occurrence of a Qualifying Event; as well as their subsequent responsibility to comply with the Plan's procedure(s) for providing notice to the Plan Administrator regarding said status.

As described above, if an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, the notice must be delivered no more than 60 days after the latest of:

1. the date of the disability determination by the SSA;
2. the date on which a Qualifying Event occurs;
3. the date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
4. the date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be provided within the first 18 months of COBRA Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1. the date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or

2. the date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed), or received by the Plan Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the person is electing COBRA Continuation Coverage, his or her coverage under the Plan will terminate on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18 month COBRA coverage period.

If you fail to give written notice within the applicable time period, the Spouse and/or Dependent Child will lose the right to elect COBRA continuation.

Any individual who is the covered Employee (or former Employee) with respect to a Qualifying Event, or any representative acting on behalf of the covered Employee (or former Employee) 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.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA on behalf of their covered spouses, and parents may elect COBRA on behalf of their covered Children. Multiple Qualifying Events that may be combined under COBRA will not ordinarily continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36 month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, entitlement of the employee to Medicare (Part A, Part B, or both), your divorce or legal separation, or a Dependent Child losing eligibility as a Dependent Child, COBRA continuation coverage can last for up to 36 months.

In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Dependent of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months equals 28 months).

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

<u>DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE</u>

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in writing in a timely manner, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified in writing of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This written notice should be sent to: Wa-Nee Community Schools, 1300 N. Main Street, Nappanee, Indiana 46550. You should include a copy of the Social Security Administration's letter which gives the effective date of the disability. The Plan can charge 150% of the premium cost for the extended period of coverage.

<u>SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE</u>

If your COBRA covered family members experience another COBRA qualifying event within the first 18 months of COBRA continuation, COBRA continuation coverage for up to an additional 18 months is available. The total months of COBRA coverage, including the COBRA extension, cannot exceed a maximum of 36 months from the original COBRA qualifying event. A COBRA extension is available to the spouse and Dependent Children if the former employee dies, or is divorced or legally separated. The COBRA extension is also available to a Dependent Child when that Child stops being eligible under the Plan as a Dependent Child. In certain limited instances, the extension may be available if the former employee becomes Medicare entitled after loss of coverage due to termination of employment or reduction in hours. **<u>In all cases, the 18-month extension occurs only if the second qualifying event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first qualifying event never occurred</u>.**

The following example shows how the second qualifying event rule works. Former employee A elects 18 months of COBRA continuation for the entire family. After the first six months of COBRA continuation, former employee A becomes entitled to Medicare (Part A, Part B, or both). If former employee A were still actively employed, entitlement to Medicare would **not** result in a loss of coverage under the Employer's health plan. <u>The additional 18-month extension is not available for the former employee's spouse and Dependents, because if Medicare entitlement had occurred during active employment there would have been no loss of employer health plan coverage</u>.

In all of these cases, you must make sure that the Plan Administrator is notified within 60 days of the second qualifying event. This notice must be sent to: Wa-Nee Community Schools, 1300 N. Main Street, Nappanee, Indiana 46550.

<u>EARLY TERMINATION OF COBRA CONTINUATION</u>

COBRA continuation will end early if the employer's group health plan terminates and the employer does not provide replacement medical coverage. COBRA continuation will also end on the first to occur of the following events.

- The qualified beneficiary first becomes covered under another group health plan after the date of the COBRA election. COBRA coverage may continue only for the remainder of the COBRA period.
- The qualified beneficiary fails to make required contributions when due.
- The qualified beneficiary becomes entitled to Medicare Part A or Part B (or both) after electing COBRA continuation coverage (except as provided under COBRA's special bankruptcy rules).
- The qualified beneficiary is extending the 18-month coverage because of Social Security disability and is no longer disabled under the COBRA Disability Extension rules described above. In this case the qualified beneficiary is required to notify the Plan Administrator of the loss of Social Security disability status within 30 days of receipt of notice from the Social Security Administration.

- The occurrence of any other event which would allow the Plan Administrator to terminate coverage without offering COBRA continuation coverage (such as the commission of fraud by the qualified beneficiary or their dependents).

Important Information When Considering a COBRA Coverage Election

When considering whether to elect COBRA continuation, the eligible person should understand that a failure to elect COBRA will affect future rights under federal law.

Federal law provides certain special enrollment rights when a COBRA-covered person becomes eligible for another group health plan (such as a plan sponsored by a spouse's employer, or the plan of a new employer). Coverage can be elected under the other group health plan within the first 30 days of eligibility.

Cost of COBRA Continuation Coverage

The COBRA beneficiary must pay the entire cost of health coverage (the employer's contribution portion and the active employee portion of the contribution), plus up to a 2% administrative fee for the duration of COBRA continuation.

If COBRA benefits are extended under the COBRA SSA Disability Extension Rules described above, the cost of COBRA is 102% of the total cost of health coverage for active employees for the first 18 months, and 150% from the 19th through the 29th month of coverage.

Other Coverage Options (The Marketplace)

There may be other coverage options for you and your family. Through the Health Insurance Marketplace at www.healthcare.gov or 1-800-318-2596 you may be able to get coverage that costs less than COBRA continuation coverage. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR

Wa-Nee Community Schools Health Care Plan is the benefit plan of **Wa-Nee Community Schools**, the Plan Sponsor. It is to be administered by the Plan Administrator. An individual may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies or is otherwise removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to: a) construe and interpret the terms and provisions of the Plan; b) to make determinations regarding issues which related to eligibility for benefits; c) to decide disputes which may arise relative to a Covered Person's rights; and d) to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them.

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

DUTIES OF THE PLAN ADMINISTRATOR

1. To administer the Plan in accordance with its terms.
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
4. To make factual findings;
5. To decide disputes which may arise relative to a Covered Person's rights.
6. To prescribe procedures for filing a claim for benefits and to review claim denials.
7. To keep and maintain the Plan documents and all other records pertaining to the Plan.
8. To appoint a Claims Administrator to pay claims.
9. To delegate to any person or entity such powers, duties and responsibilities, as it deems appropriate.
10. To perform each and every function necessary for or related to the Plan's administration.

Plan Administrator Compensation – The Plan Administrator serves without compensation; however all expenses for Plan administration, including compensation for hired services, will be paid by the Plan.

Fiduciary – A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties – A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties that must be carried out:

1. with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
2. by diversifying the investments of the Plan (if any) so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

3. in accordance with the Plan documents to the extent that they agree with ERISA.

The Named Fiduciary – A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

2. the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

Claims Administrator is not a Fiduciary – A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage – Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The Plan Administrator will set the level of any Employee contributions. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

Escheat Laws Do Not Apply – Where a Covered Person or medical provider receives payment by check for Plan benefits, and the check remains outstanding for 12 months after issue, it will be cancelled and the amount credited to the Plan's account. The unclaimed funds so credited shall be treated as Plan assets and applied to the payment of current benefits under the Plan. In the event the Covered Person or medical provider to whom the check was originally issued later makes a claim for payment, the Plan shall pay said claim under the terms and provisions in effect when the claim was originally Incurred.

LEGAL ENTITY; SERVICE OF PROCESS

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in the Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Covered Person, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination.

The Plan Sponsor intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part, in its sole discretion. This includes amending the benefits under the Plan or the Trust agreement (if any).

Any such amendment, suspension or termination shall be enacted and in accordance with applicable law. In the event the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable law and any applicable governing documents.

SUMMARY OF MATERIAL REDUCTION (SMR)

A Material Reduction generally means any modification that would be considered by the average Covered Person to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in deductibles or co-payments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Covered Person. The 60-day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

Material Reduction disclosure provisions are subject to the requirements of ERISA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

SUMMARY OF MATERIAL MODIFICATION (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to Deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective.

Note: *The Patient Protection and Affordable Care Act (PPACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Covered Persons at least 60 days before the effective date of the Material Modification.*

MISUSE OF IDENTIFICATION CARD

If an Employee or covered Dependent permits any person who is not a Covered Person of the Family Unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of 31 days from the date written notice is given.

COMPLIANCE WITH APPLICABLE LAWS

The Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under

this Plan, such payments will be considered as being in accordance with the terms of this Plan Document.

MENTAL HEALTH PARITY

Under a Federal law know as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. Wa-Nee Community Schools has elected to be exempt from the following requirements:

1. Parity in the application of certain limits to mental health benefits. Group health plans (of employers that employ more than 50 employees) offering mental health benefits may not set annual or lifetime dollar limits on mental health benefits that are lower than limits for medical and surgical benefits. A plan that does not impose an annual or lifetime dollar limit on medical and surgical benefits may not impose that type of limit on mental health benefits. These requirements do not apply to benefits for substance abuse or chemical dependency.

   The exemption from these Federal requirements will be in effect for the 2018-2019 plan year beginning December 1, 2018 ending November 30, 2019. The election may be renewed for subsequent plan years.

FRAUD

The following actions by any Covered Person, or a Covered Person's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire Family Unit of which the Covered Person is a member:

1. attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;

2. attempting to file a claim for a Covered Person for services which were not rendered or Prescription Drugs or other items which were not provided; or

3. providing false or misleading information to the Plan.

LIMITATIONS ON LEGAL ACTIONS

All claims review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of benefits or for a fiduciary's breach of duty must be commenced within one year after the Plan's claim review procedures have been exhausted.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded health plan and the administration is provided through a third party claims administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

APPLICABLE LAW

This Plan is a governmental (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a Federal law regulating Employee welfare and pension plans. Your rights as a Covered Person in the Plan are governed by the plan documents and applicable State law and regulations. This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations.

CLERICAL ERROR/DELAY

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

STATEMENTS

All statements made by the Company or by a Covered Person will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Covered Person.

Any Covered Person who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Covered Person may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Covered Person, the Plan Administrator in its sole discretion may terminate the interest of such Covered Person or former Covered Person in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Covered Person or former Covered Person, his/her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Covered Person or former Covered Person, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

UNCLAIMED SELF-INSURED PLAN FUNDS

In the event a benefits check issued by the Claims Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to

this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Covered Person subsequently requests payment with respect to the voided check, the Claims Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan.

NOTICE OF GRANDFATHERED STATUS

Patient Protection and Affordable Care Act

This group health plan believes this plan is a "Grandfathered Health Plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a Grandfathered Health Plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a Grandfathered Health Plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to Other Plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, Grandfathered Health Plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a Grandfathered Health Plan and what might cause a plan to change from Grandfathered Health Plan status can be directed to the Plan Administrator at the following address:

Wa-Nee Community Schools
1300 N Main Street
Nappanee, IN 46550

You may also contact the U.S. Department of Health and Human Services at http://www.hhs.gov/. In addition, the following website has additional information regarding Grandfathered Health Plans: https://www.healthcare.gov/what-if-i-have-a-grandfathered-health-plan/.

PLAN NAME **Wa-Nee Community Schools Health Care Plan**

PLAN NUMBER 501

TAX ID NUMBER 35-1074003

PLAN EFFECTIVE DATE December 31st

PLAN YEAR ENDS November 30th

RESTATED December 1, 2018

PLAN STATUS Grandfathered

EMPLOYER INFORMATION

Wa-Nee Community Schools
1300 N. Main Street
Nappanee, Indiana 46550
574-773-3131

AGENT FOR SERVICE OF LEGAL PROCESS

Wa-Nee Community Schools
1300 N. Main Street
Nappanee, Indiana 46550

PLAN ADMINISTRATOR

Wa-Nee Community Schools
1300 N. Main Street
Nappanee, Indiana 46550
574-773-3131

CLAIMS ADMINISTRATOR

Group Administrators, Ltd.
915 National Parkway, Suite F
Schaumburg, Illinois 60173
847-519-1880
www.groupadministrators.com

NAMED FIDUCIARY

Wa-Nee Community Schools
1300 N. Main Street
Nappanee, Indiana 46550

COBRA ADMINISTRATOR

Group Administrators, Ltd.
915 National Parkway, Suite F
Schaumburg, Illinois 60173
847-519-1880
www.groupadministrators.com

HUMAN RESOURCES CONTACT FOR CREDITABLE COVERAGE CERTIFICATE

Human Resources Department
Wa-Nee Community Schools
1300 N. Main Street
Nappanee, Indiana 46550
574-773-3131

BENEFIT PLAN DESIGNED BY

Burt Advisory Group, Inc.
307 South Main Street, Suite 302
Elkhart, Indiana 46516

The Plan Sponsor hereby adopts this Plan Document as the written description of the Plan.

IN WITNESS WHEREOF, this instrument is executed for **Wa-Nee Community Schools** on or as of the day and year first being written.

By: Randi Libby
Wa-Nee Community Schools

Date: 02/28/2019

Witness: [signature]

Date: 3/4/2019