KUSPUK SCHOOL DISTRICT
EMPLOYEE HEALTH CARE PLAN

PLAN DOCUMENT
AND
EMPLOYEE BENEFIT BOOKLET

RESTATED JULY 1, 2020

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KUSPUK SCHOOL DISTRICT EMPLOYEE HEALTH CARE PLAN

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1 INTRODUCTION

Kuspuk School District (the "Employer" or "Company") is pleased to offer you this benefit Plan. It is a valuable and important part of your overall compensation package.

This booklet describes your medical and prescription drug benefits, dental benefits, vision benefits and serves as the Summary Plan Description (SPD) and Plan document for the KUSPUK SCHOOL DISTRICT EMPLOYEE HEALTHCARE PLAN ("the Plan").

This document sets forth the provisions of the Plan that provide for payment or reimbursement of Plan benefits. It is written to comply with disclosure requirements under the Employee Retirement Income Security Act ("ERISA") of 1974, as amended.

We encourage you to read this booklet and become familiar with your benefits. You may also wish to share this information with your enrolled family members.

This Plan and SPD replace all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference.

Kuspuk School District believes this Plan is a "grandfathered health Plan" under the Patient Protection and Affordable Care Act ("Affordable Care Act"). As permitted under 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 provisions of preventive health care services without any cost sharing. However, grandfathered 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: Kuspuk School District, PO Box 49 Aniak, AK, 99557, 907-675-4250.

You may also contact the Employee Benefits Security Administration, U. S. Department of Labor at 1-866-444-3272, or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered Plans

2 ADOPTION OF THE PLAN DOCUMENT

2.1 Adoption

Plan Sponsor hereby adopts this Plan Document as the written description of its employee welfare benefit plan (the "Plan"). This Plan Document replaces any prior statement or the health care coverages of the Plan and is effective on the date shown below.

2.2 Purpose of the Plan

The purpose of the Plan is to provide certain benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents. The benefits provided by the Plan include:

- Medical Coverage
- Prescription Drug Coverage
- Dental Coverage
- Vision Coverage

2.3 Intent to Comply with ERISA

It is intended that the Plan Document will serve to describe the nature, funding and benefits of the Plan. It is also intended that the Plan will conform to the requirements found in the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time, as that act applies to employee welfare benefit plans. If any portion of the Plan does now, or in the future, conflict with ERISA or Federal regulations, such regulations will govern.

2.4 Conformity with Law

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

2.5 Participating Employers

Employers participating in this Plan are as stated in the section entitled General Plan Information.

The Plan Sponsor may act for and on behalf of any and all of the Participating Employers in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor will be binding on all such Employers.

2.6 Acceptance of the Plan Document

IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument be executed, effective as of July 1, 2020.

Table 2.1: Signature of Adoption of Plan Document

Kuspuk School District	
By: [signature]	Title: Business Manager
Date: 9/22/2020	

3 IMPORTANT INFORMATION

3.1 Who To Contact For Additional Information

A participant can obtain additional information about coverage of a specific drug, treatment, procedure, preventive service, etc. from the office that handles claims on behalf of the Plan (the "Contract Administrator"). See the first page of the **General Plan Information** section for the name, address and phone number of the Contract Administrator.

3.2 COBRA Notice Procedures

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

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

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

3.3 The Newborns' and Mothers' Health Protection Act

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

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

3.4 The Women's Health and Cancer Rights Act

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

Plan participants must be notified, upon enrollment and annually thereafter, of the availability of benefits required due to the Women's Health and Cancer Rights Act (WHCRA).

3.5 Definitions

Some of the terms used in this document begin with a capital letter. These terms have special meanings and are included in the **Definitions** section. When reading this document, it will be

helpful to refer to this section. Becoming familiar with the terms defined therein will provide a better understanding of the benefits and provisions.

4 NOTICE OF RIGHT TO RECEIVE A CERTIFICATE OF CREDITABLE COVERAGE

Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a "certificate of creditable coverage" or "certificate of group health plan coverage," from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates (including termination due to exhaustion of all lifetime benefits), the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

5 UTILIZATION MANAGEMENT PROGRAM

The Plan includes a **Utilization Management Program** as described below. The purpose of the program is to encourage Covered Persons to obtain quality medical care while utilizing the most cost efficient sources.

5.1 Pre-Service Review Requirements

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

5.2 Compliance Procedures

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

Inpatient Admission - Except as noted, at least ten (10) business days (or as soon as possible) prior to any non-emergency Inpatient admission to a Hospital or Skilled Nursing Facility, the Covered Person or someone acting on his behalf must contact the Utilization Management Organization for pre-service review and authorization. For an emergency admission, the Utilization Management Organization must be contacted within 48 hours of the first business day after admission.

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

NOTE: Pre-service review will not be required for an Inpatient admission for Pregnancy delivery that does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. However, if/when the Pregnancy confinement for the mother or newborn is expected to exceed these limits, pre-service review for such extended confinement is required.

Breast Prosthetics – Prior authorization is required for repair, replacement or removal of breast prostheses.

Second (or Third) Surgical Opinion -Prior to the performance of any elective (non-emergency) surgical procedures, the Covered Person or someone acting on his behalf, must contact the Utilization Management Organization to determine if a second (or third) surgical opinion is required.

Specified Outpatient Services & Supplies -Prior to receipt of the following services, the Covered Person or someone acting on his behalf must contact the Utilization Management Organization for authorization:

Outpatient surgery

Home health care

Hospice care

5.3 Penalty for Non-Compliance

If the above pre-service review requirements are not completed, benefits may be reduced by $250.

Any additional share of expenses that becomes the Covered Person's responsibility for failure to comply with these requirements will not be considered eligible medical expenses and thus will not apply to any deductibles, coinsurance or out-of-pocket maximums of the Plan.

See "Pre-Service Claims" in the **Claims Procedures** section for more information, including information on appealing an adverse decision (i.e. a benefit reduction) under this program.

NOTE: The Plan will not reduce or deny a claim for failure to obtain a prior approval under circumstances that would make obtaining pre-service review impossible or where application of the pre-service review process could seriously jeopardize the life or health of the patient (e.g., the patient is unconscious and is in need of immediate care at the time medical treatment is required).

5.4 More Information About Pre-Service Review

It is the **Employee's or Covered Person's responsibility** to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an Employee should contact the review organization to make certain that the facility or attending Physician has initiated the necessary processes.

Pre-service review and authorization is **not a guarantee of coverage**. The **Utilization Management Program** is designed ONLY to determine whether or not a proposed setting and course of treatment is Medically Necessary and appropriate. Plan benefits will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions. Nothing in the **Utilization Management Program** will increase benefits to cover any confinement or service that is not Medically Necessary or that is otherwise not covered hereunder.

6 CASE MANAGEMENT SERVICES

In situations where extensive or ongoing medical care will be needed, the Utilization Management Organization may, with the patient's and Plan Sponsor's consent, provide case management services. Such services may include contacts with the patient, his family, the primary treating Physician, other caregivers and care consultants, and the hospital staff as necessary.

The Utilization Management Organization will evaluate and summarize the patient's continuing medical needs, assess the quality of current treatments, coordinate alternative care when appropriate and approved by the Physician and Plan Sponsor, review the progress of alternative treatment after implementation, and make appropriate recommendations to the Plan Sponsor.

The Plan Sponsor expressly reserves the right to make modifications to Plan benefits on a case-by-case basis to assure that appropriate and cost-effective care can be obtained in accordance with these services.

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

7 MEDICAL BENEFIT SUMMARY

7.1 Choice of Providers

The Plan Sponsor (Kuspuk School District) has contracted with an organization or "Network" of health care providers. The Network is:

First Choice Health Network

Address: **c/o Integrity Administrators, Inc.**

P. O. Box 13128

Sacramento, CA 95813

Phone: **FCHN** (800) 231-6935

Website: www.fchn.com

For out-of-Alaska services (i.e., for persons who are traveling or who reside outside of the First Choice Health Network area), the Plan has a secondary network agreement. To find a provider who is in the secondary network, a Covered Person can contact **the claims administrator's office at (800) 562-9383**.

When obtaining health care services, a Covered Person has a choice of using providers who are participating in the Network or any other Covered Providers of his choice (Non-Network providers).

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

The Plan Sponsor will automatically provide a Plan participant with information about how he can access a directory of Network Providers. This information will be provided without charge. The directories will be available either in hard copy as a separate document, or in electronic format. Since certain covered services and supplies may not be available through a Network, a Covered Person should refer to the Network list or directory to determine if any particular specialty is included.

Although there may be circumstances when a Network provider cannot be used, Non-Network provider services will be covered at the Non-Network benefit levels. However, in the following limited circumstances, Non-Network provider expenses will be covered at the Network benefit levels. The Network benefit levels will be applied to Non-Network Usual, Customary and Reasonable charges:

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

Referrals – If a Network provider refers a Covered Person to a Non-Network Provider, any such expenses will be covered at the Network benefit levels.

Specialists – If a covered person is referred by a Network Provider to a specialist and there is not one represented in Anchorage, AK at the time of services, a Non-Network provider may be used in an attempt to eliminate extensive out of pocket travel expenses. Such specialist care will be covered at Network benefit levels.

8 SCHEDULE OF MEDICAL BENEFITS

The percentages shown in the following schedule reflect the amounts the Plan pays of Eligible Expenses after any required Deductible has been applied. The percentages apply to "Usual, Customary and Reasonable" charges. For Network providers, this means that the percentages apply to the negotiated rates. See "Usual, Customary and Reasonable" in the **Definitions** section for more information.

Table 8.1: Maximum Annual Benefit	
Maximum Annual Benefit	Unlimited

Table 8.2: Calendar Year Deductibles	
Individual Deductible	$100
Family Maximum Deductible	$300

8.1 Individual Deductible

The Individual Deductible is an amount of Eligible Expenses that a Covered Person must pay each year. The deductible usually applies before the Plan begins to provide benefits.

8.2 Family Maximum Deductible

If $300 in eligible medical expenses is incurred collectively by family members during a Calendar Year and is applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and his covered Dependents.

8.3 Deductible Carry-Over

Eligible Expenses incurred in the last 3 months of a Calendar Year and applied toward that year's Deductible can be carried forward and applied toward the person's Deductible for the next Calendar Year.

8.4 Common Accident Provision

If 2 or more Covered Persons who are members of the same family are injured in the same accident, only 1 Individual Deductible will be taken from the total eligible medical expenses incurred as the result of such accident during the Calendar Year in which the accident occurred. The Individual Deductible requirement for each member of the family who is involved in the accident will be credited with a pro-rata share of the 1 Individual Deductible amount applied to accident-related expenses.

Table 8.3: Individual Out of Pock Maximums	
Network	$390
Non-Network	Unlimited

Except as noted, a Covered Person will not be required to pay more than $390 in any Calendar Year toward his share of Network Eligible Expenses that are not paid by the Plan. Once he has paid his out-of-pocket maximum, his Network Eligible Expenses will be paid at 100% for the balance of the Calendar Year. The out-of-pocket maximum for Non-Network expenses is not limited.

NOTE: The Network out-of-pocket maximum does not apply to or include: amounts applied or paid to satisfy any Deductible requirement; expenses related to dental, vision or hearing care; expenses that become the Covered Person's responsibility for failure to comply with the requirements of the **Utilization Management Program**.

Table 8.4: Eligible Medical Expenses		
Eligible Medical Expense	**Network**	**Non-Network**
Ambulance/ Air Travel Service Air ambulance is limited to life-threatening situations. Air travel service is limited to 2 round trips per Covered Person, per Calendar Year. **Only First Choice Health Network providers will be paid at the PPO benefit level. All Non-PPO air ambulance providers will be paid at the Non-PPO level of benefits as stated.**	80%	60%
Hearing Exams & hearing Aids Hearing exams are limited to 1 exam every 3 Calendar Years. Hearing aids are limited to 1 device every 3 Calendar Years.	80%	80%
Hospice Care Inpatient and Outpatient Hospice care is limited to a maximum 6 month period of care. Inpatient care is limited to 14 days per lifetime.	80%	60%
Hospital Services (Inpatient or Outpatient) Eligible Expenses for Inpatient room and board are limited: (1) at a Network Hospital, to the Network negotiated rates and, (2) at a Non-Network Hospital, to the Semi-Private Room Charge (see Definitions) or the Usual, Customary and Reasonable charge for an Intensive Care Unit. Excess charges for a private room accommodation will be covered only when isolation of the patient is Medically Necessary and is ordered by the attending Physician to protect the health of the patient or others.	80%	60%
Mental Health Care		
Facility Services & Supplies	80%	60%
Professional Services	80%	60%
Physician Services	80%	60%
Prescription Drugs, Outpatient	**(**see Prescription Benefit Summary Section**)**	
Preventive Care (see full description of Preventive Care Benefits under Eligible Medical Expenses)	100%	100%
Skilled Nursing Facility Eligible expenses for room and board are limited to the facility's Semi-Private Room Charge. Coverage is limited to 90 days per Calendar Year.	80%	60%
Substance Abuse Care		
Facility Services & Supplies	80%	60%
Professional Services	80%	60%
Transplant Related Expenses Transplant-related benefits are limited as follows: Donor organ procurement benefits are limited to $10,000 per transplant. Benefits for travel, lodging and meals are limited to a combined maximum of $2,500 per transplant. Benefits for lodging and meals costs are further limited to $200 per day; Private duty nursing benefits are limited to $10,000 per transplant.	(benefits are based on types of services rendered)	
All Other Eligible Medical Expenses	80%	60%

THIS IS A SUMMARY ONLY. SEE THE **ELIGIBLE MEDICAL EXPENSES** AND **MEDICAL LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION.

9 ELIGIBLE MEDICAL EXPENSES

This section is a listing of those medical services, supplies and conditions that are covered by the Plan. This section must be read in conjunction with the **Medical Benefit Summary** to understand how Plan benefits are determined (e.g., application of Deductible and Co-Pay requirements and benefit sharing percentages). All medical care must be received from or ordered by a Covered Provider.

Except as otherwise noted below or in the **Medical Benefit Summary**, eligible medical expenses are the Usual, Customary and Reasonable charges for the items listed below and that are incurred by a Covered Person - subject to the **Definitions**, **Limitations and Exclusions** and all other provisions of the Plan. In general, services and supplies must be approved by and received from a Physician or other appropriate Covered Provider and must be Medically Necessary for the care and treatment of a covered Sickness, Accidental Injury, Pregnancy or other covered health care condition.

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

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

9.1 Acupuncture

Acupuncture treatment when provided by a Physician (MD or DO) in lieu of general anesthesia.

NOTE: Except as expressly stated above, acupuncture, acupressure, services of a massage therapist, rolfing, reflexology or faith healing is not covered.

9.2 Alcoholism

See "Substance Abuse Care"

Allergy Testing & Treatment

Allergy testing and treatment, including allergy injections.

9.3 Ambulance / Air Travel Service

Professional ground ambulance or professional air ambulance service in a life-threatening situation.

Round trip air transportation provided by a commercial airline from the place where a Sickness or Accidental Injury occurs to the nearest Hospital or treatment facility equipped to treat the condition, subject to the following:

- the Sickness or Accidental Injury must be a life-threatening situation that requires immediate transfer to a Hospital that has special facilities for treatment of the condition; or
- a surgery is needed that cannot be performed locally or a condition exists that cannot be treated locally. The attending Physician must provide written certification and detailed medical documentation of the condition.

If the patient/Covered Person is a Dependent child under age 18, transportation expenses of a parent or legal guardian accompanying the child will be allowed, provided the patient or legal guardian is also a Covered Person and the attending Physician certifies the need for such attendance. Such expenses will be treated as expenses of the child.

Please note: Only First Choice Health Network providers will be paid at the PPO benefit level. All Non-PPO air ambulance providers will be paid at the Non-PPO level of benefits as stated.

9.4 Ambulatory Surgical Center
Services and supplies provided by an Ambulatory Surgical Center (see Definitions) in connection with a covered Outpatient surgery.

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

9.6 Birthing Center
Services and supplies provided by a Birthing Center (see **Definitions**) in connection with a covered Pregnancy.

9.7 Blood
Blood and blood derivatives (if not replaced by or for the patient), including blood processing and administration services.

9.8 Chemical Dependency
See "Substance Abuse Care".

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

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

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

9.11 Diabetic Supplies
See the Prescription Benefit Summary.

9.12 Diagnostic Lab & X-ray, Outpatient
Laboratory, X-ray and other non-surgical services performed to diagnose medical disorders, including scanning and imaging work (e.g., CT scans, MRIs), electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the United States.

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

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

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

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

9.15 Hearing Exams & Hearing Aids

A hearing exam by an appropriate Covered Provider (see NOTE) and a hearing device obtained as a result of the exam.

The Covered Person must obtain a written affirmation from the examining Physician stating that he is suffering from a hearing loss that may be lessened by use of a hearing aid device. Such written confirmation must be provided within a 3-month period prior to the purchase of the hearing aid.

NOTE: Eligible expenses do not include:

- a hearing exam if a hearing device is not obtained as the result of the exam;
- batteries or other ancillary equipment, other than when obtained upon purchase of the hearing aid,
- a device more expensive than the one prescribed by the examining Physician;
- hearing aid expenses incurred after termination of coverage except when the device is prescribed by a Physician, is ordered prior to termination, and is delivered within thirty (30) days after date of termination.

9.16 Home Health Care

Services and supplies that are furnished to a Covered Person in accordance with a written home health care plan. The home health care plan must be established by the Covered Person's attending Physician and the Physician must certify that the condition would require continued Inpatient confinement in a Hospital in the absence of home health care.

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

- part-time or intermittent services of a registered nurse (RN) or a licensed practical nurse (LPN);
- services of physical, occupational and speech therapists;
- part-time or intermittent services of home health aides under the supervision of a registered nurse (RN) or a physical, occupational or speech therapist; and
- medical supplies, drugs and medicines prescribed by a Physician and laboratory services, but only to the extent that such items would have been covered if the patient had continued to be confined in the Hospital.

NOTE: Covered home health care expenses will not include food, food supplements, home-delivered meals, transportation, housekeeping services or other services that are custodial in nature and could be rendered by nonprofessionals.

9.17 Hospice Care
Hospice care of a Covered Person with a terminal prognosis (i.e., a life expectancy of six months or less). Eligible Expenses include:

- Inpatient Hospice care including room and board, ancillary services furnished by the Hospice and rental of durable medical equipment which is used solely for treating the terminal condition;
- at-home services and supplies including:
    - medical supplies and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the condition;
- Physician services and/or nursing care by a registered nurse (RN), licensed practical nurse (LPN), or a licensed vocational nurse (LVN);
- home health aide services;
- care furnished by a Hospital or Home Health Care Agency under the direction of a Hospice. Custodial care will be included if it is provided during a regular visit by an RN, an LPN, or a home health aide;
- medical social services by a licensed or trained social worker, psychologist or counselor;
- nutrition services provided by a licensed dietitian;
- respite care (i.e., services of professionals to provide temporary relief to family members caring for the patient); and
- bereavement counseling.

9.18 Hospital Services
Hospital services and supplies provided on an Outpatient basis and Inpatient care, including daily room and board and ancillary services and supplies.

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

9.20 Medicines
Medicines that are dispensed and administered to a Covered Person during an Inpatient confinement, during a Physician's office visit, or as part of a home health care or hospice care program.

9.21 Mental Health Care
Inpatient treatment of a mental health condition when provided in a general Hospital.

Outpatient care when services are provided by a Physician (MD or DO), a psychiatrist (MD), psychologist (PhD), or a counselor with the degree of MSW, LCSW, MA, MFC or LPC who is acting under the direct supervision of a Physician (MD or DO) and whose expenses are billed through that Physician.

For Plan purposes, "mental health conditions" include schizophrenic disorders, paranoid disorders, affective disorders (depression, mania, and manic-depressive illness), anxiety disorders, somatoform disorders, personality disorders, and disorders of infancy, childhood and adolescence. If a combined diagnosis of mental illness and substance abuse/chemical dependency is given, benefits will be determined based on the diagnosis that is determined to be the major illness.

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

- learning and behavior disorders including attention deficit disorder, hyperkinetic syndrome, autism or mental retardation;
- mental exams or psychological testing or evaluation not provided as an adjunct to treatment of a mental disorder (e.g., mental exams for the purpose of adjudication legal rights, administrative awards or benefits, correction or social service placement or any use except as a diagnostic tool for the provision of mental health care);
- hypnotherapy;
- marriage and family counseling;
- sex counseling or sex therapy;
- vocational testing or training.

9.22 Midwife
Services of a certified or registered nurse midwife when provided in conjunction with a covered Pregnancy - see "Pregnancy Care" below.

9.23 Newborn Care
Medically Necessary services and supplies, as listed herein, for a covered newborn that is sick or injured. Also see “Pregnancy Care.”

9.24 Nursing Services
Nursing care by a Covered Provider when the Covered Peron’s attending Physician certifies that nursing care is necessary.

Private-duty nursing care by a licensed practical nurse (LPN) or registered nurse (RN) while a Covered Person is confined in a Hospital.

Private-duty services of a registered nurse (RN) when provided on an Outpatient basis.

9.25 Occupational Therapy
See “Rehabilitation Therapy”

9.26 Orthotics
Orthopedic (non-dental) braces, casts, splints, trusses and other orthotics that are prescribed by a Physician and that are required for support of a body part due to a congenital condition, or an Accidental Injury or Sickness.

NOTE: Foot orthotics are not covered.

9.27 Oxygen
See "Durable Medical Equipment"

9.28 Parenteral Nutrition (Intravenous Feeding)
Hyperalimentation or total parenteral nutrition (TPN) for persons recovering from or preparing for surgery.

9.29 Physical Therapy
See “Rehabilitation Therapy”.

9.30 Physician Services
Medical and surgical treatment by a Physician (MD or DO), including office, home or Hospital visits, clinic care and consultations. See "Second (& 3rd) Surgical Opinion" below for requirements applicable to surgery opinion consultations.

9.31 Pregnancy Care
Pregnancy-related expenses of a covered Employee or covered Dependent spouse. Eligible

Pregnancy-related expenses include the following, are covered at least to the same extent as any other Sickness, and may include other care that is deemed to be Medically Necessary by the patient's attending Physician:

- pre-natal visits and routine pre-natal and post-partum care;
- expenses associated with a normal or cesarean delivery as well as expenses associated with any complications of pregnancy;
- genetic testing (e.g., amniocentesis) or counseling when deemed Medically Necessary by a Physician;
- up to five (5) days of newborn nursery room and board expenses during the mother's confinement for delivery. If the newborn is a Covered Person and is ill or injured, the expenses are covered as the newborn's own claim.

In accordance with the Newborns' and Mothers' Health Protection Act, the Plan will not restrict benefits for a Pregnancy Hospital stay for a mother and her newborn to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section. Also, the **Utilization Management Program** requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the decision is made between the attending Physician and the mother.

NOTE: Pregnancy coverage will not include: (1) Lamaze and other charges for education related to pre-natal care and birthing procedures, (2) adoption expenses, (3) expenses of a surrogate mother who is not a Covered Person, or (4) any pregnancy-related expenses of a Dependent daughter, even for complications of pregnancy.

9.32 Prescription Drugs
Medicines that are dispensed and administered to a Covered Person during an Inpatient confinement, during a Physician's office visit, or as part of a home health care or hospice care program.

Other Outpatient drugs (i.e., pharmacy purchases) are covered through a separate program. See the **Prescription Benefit Summary** for additional information.

9.33 Preventive Care

Preventive Care Benefits are to promote wellness, disease prevention and early detection by encouraging the Plan's Covered Persons to have regular preventive examinations to identify potential health risks and provide the opportunity for early intervention.

Services are considered Preventive Care when a Covered Person:

- Does not have symptoms or any abnormal studies indicating an abnormality at the time the service is performed;
- Has had a screening done within the age and gender guidelines recommended by the U.S. Preventive Services Task Force with the results being considered normal;
- Has a diagnostic service with normal results, after which the physician recommends future preventive care screening using the appropriate age and gender guidelines recommended by the U.S. Preventive Services Task force, or
- Has a preventive service done that results in a diagnostic service being done at the same time because it is an integral part of the preventive service (e.g. polyp removal during a preventive colonoscopy).

If a health condition is diagnosed during a preventive care exam or screening, the preventive exam or screenings still qualifies for preventive care coverage.

Services are considered Diagnostic Care, and not Preventive Care, when;

- Abnormal results on previous preventive or diagnostic screening requires further diagnostic testing or services,
- Abnormal test results found on a previous preventive or diagnostic service requires the same test to be repeated sooner than normal age and gender guideline as recommended by the U.S. Preventive Services Task Force would require, or
- Services are ordered due to current symptom(s) that require further diagnosis.

The Plan will pay for Preventive Care Services only if the service;

- Falls within the scope of a Preventive Care Service as indicated above; and
- Is identified as a covered preventive service on the US Department of Health and Human Services (HHS) list of Preventive Care services.

A list of the Preventive Care services can be found on the US Department of Health and Human Services (HHS) website at https://www.healthcare.gov/what-are-my-preventive-care-benefits. The services listed on the HHS website are not subject to co-payment or deductible, and will be paid at 100% of the provider's rate, regardless of whether the provider is a PPO or non-PPO Provider.

9.34 Prosthetics

Artificial limbs or eyes to replace natural body parts lost or missing due to Accidental Injury, surgery, or a congenital anomaly of a child.

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

Repair or replacement of a prosthetic when required due to physiological changes.

9.35 Radiation Therapy
See "Chemotherapy & Radiation Therapy".

9.36 Rehabilitation Therapy
Multi-disciplinary Inpatient or Outpatient therapy furnished by a Physician, a licensed or certified therapist, or at a freestanding duly-licensed Outpatient therapy facility. Therapy services include but are not limited to: physical, speech and occupational therapy and rehabilitative treatment for a congenital anomaly for a dependent child.

9.37 Respiratory / Inhalation Therapy
Professional services of a licensed respiratory or inhalation therapist, when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of respiratory function.

9.38 Second (& 3rd) Surgical Opinion
A second surgical opinion consultation following a surgeon's recommendation for surgery. The Physician rendering the second opinion regarding the Medical Necessity of a proposed surgery must be qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

A third opinion consultation if the second opinion does not concur with the first Physician's recommendation. This third Physician must be qualified to render such a service and must not be affiliated in any way with the Physician who will be performing the actual surgery.

9.39 Skilled Nursing Facility / Extended Care Facility
Inpatient care in Skilled Nursing Facility or Extended Care Facility when admission to the facility is Medically Necessary, is ordered by a Physician, begins within seven (7) days of discharge from a Hospital confinement of at least three (3) days in duration and for the same or related conditions(s).

NOTE: Benefits will not be provided for custodial care, maintenance, non-medical self-help, recreational, vocational, educational therapy, mental health care, chemical dependency rehabilitative treatment or gym or swim therapy.

9.40 Speech Therapy
Inpatient and Outpatient services of a licensed speech therapist, under the supervision of a Physician, for restorative speech therapy for speech loss or impairment due to a Sickness or Accidental Injury, or when due to surgery performed on account of a Sickness or Accidental Injury, other than a functional nervous disorder.

Also see "Rehabilitation Therapy."

NOTE: Eligible Expenses do <u>not</u> include those for treatment of disorders such as tongue thrust, stuttering, stammering, or other speech and articulation disorders.

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

NOTE: Reconstruction (reversal) of a prior elective sterilization procedure is not covered.

9.42 Substance Abuse Care
Inpatient and Outpatient treatment of substance abuse and addiction, including Inpatient detoxification, group and individual psychotherapy, behavior therapy, recreation therapy, and family therapy for the patient and the Covered Person's family.

For Plan purposes, "substance abuse and addiction" is abuse of and physical and/or psychological dependence on drugs, narcotics, alcohol, toxic inhalants, or other addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine. If a combined diagnosis of mental illness and substance abuse/chemical dependency is given, benefits will be determined based on the diagnosis that is determined to be the major illness

9.43 TMJ / Jaw Joint Treatment
Treatment of temporomandibular joint (TMJ) disorders including conditions of structures linking the jawbone, skull, and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Eligible Expenses include:

- diagnostic X-ray services;
- oral surgery;
- transcutaneous electrical nerve stimulation (TENS); and
- any appliance that is attached to or rests on the teeth.

9.44 Transplant-Related Expenses (Human Tissue)
Eligible Expenses incurred by a Covered Person who is the recipient of a human organ or tissue transplant that is not experimental or investigational in nature. All potential transplants will be assessed for appropriateness through Case Management Services (see the **Utilization Management Program** section).

Expenses of an organ donor if both the donor and the transplant recipient are Covered Persons hereunder. Donor expense includes organ and tissue procurement (removal, surgical storage and transportation costs incurred and directly related to the donation an organ used in a covered transplant procedure).

If an organ donor is a Covered Person but the transplant recipient is not, then the donor's expenses are not covered. However, complications and unforeseen effects from a Covered Person's organ donation will be covered as any other Sickness.

NOTE: Transplant benefits are not available for artificial or non-human organ implants or transplants.

9.45 Urgent Care Facility
Eligible Medical Expenses, as defined herein, that are incurred by a Covered Person at an Urgent Care Facility.

10 COVID-19 PANDEMIC

10.1 Voluntary Compliance of the Emergency Temporary Alaska Regulations

On March 11, 2020, the Governor of the State of Alaska issued a Declaration of Public Health Disaster Emergency Order. This order was issued to protect Alaskans from the adverse effects of the COVID-19 Pandemic.

This Plan voluntarily complies with the emergency temporary regulations in accordance with Alaska's Division of Insurance and the Centers for Disease Control (CDC) requirements put forth in Bulletin B20-11: Requirements for Group Health Plans, Claims, and Telehealth Related to the COVID-19 Pandemic Public Health Disaster Emergency, and Bulletin B20-12: Temporary Suspension of Certain Utilization Review and Notification Requirements; during the COVID-19 Pandemic Health Disaster Emergency.

Both Bulletin B20-11 and Bulletin B20-12 are implemented on a voluntary compliance for this plan.

Therefore, in response to Bulletin B20-11, the following items are temporarily incorporated into this Plan.

- **Reduced Work Hours**

  It is understood that during the period of the COVID-19 Pandemic, and in accordance with direction of the State of Alaska, this Plan will allow an employee to remain covered under the Plan even if the employee would otherwise become ineligible due to a decrease in hours worked per week. The Plan will continue providing coverage to employees regardless of any "actively at work" or similar eligibility requirement in the Plan document.

- **Claim Submissions and Appeals**

  Due to potential staffing challenges in physician's offices, clinics and hospitals during the Alaska public health disaster emergency, the Plan shall suspend deadlines for claim filing and appeals. Following the end of the emergency, there may also be a backlog of insurance claims to be filed and these claims may also be extended.

- **Additional Telehealth Guidance**

  During the COVID-19 Pandemic services that can appropriately be offered through telehealth in order to avoid unnecessary exposure to the virus and prevent regression of symptoms will be covered.

- **Access to Prescriptions**

  In addition to the early refills, the Plan will cover off-formulary prescription drugs if there is not a formulary drug to treat a covered condition due to supply shortages related to COVID-19. The Plan will minimize prior authorization requirements to ensure that Plan members have access to the medications as needed.

In addition, in response to Bulletin B20-12, the following items are also temporarily incorporated into this Plan.

- **Temporary Suspension of Certain Utilization Review and Notification Requirements**

  It is understood that during the period of the COVID-19 Pandemic hospitals may lack the staffing resources to respond to certain Utilization Review and Notification Requirements. As hospitals plan for these higher demands of Inpatient Hospital Services and deploy staff to provide direct patient care, their ability to perform certain administrative functions may be impacted. Moreover, with many hospitals delaying or suspending scheduled procedures, the need for certain administrative functions may be diminished. Because of this, certain Utilization Review and Notification Requirements will be suspended until June 1, 2020, subject to further evaluation, as the COVID-19 situation develops, as determined by the appropriate officials of the State of Alaska.

- **Government Facilities**

  It may become necessary for alternate medical hospital/clinical sites to be opened to handle hospital overcrowding. The Plan may currently contain exclusions or requirements for such facilities to hold specific licenses. This amendment waives such requirements so that the Plan Administrator may pay claims for covered services when members are billed for services located at sponsored by, or facilitated by the local, state, or federal government during this pandemic until such time that these alternate sites are closed.

- **Suspension of Preauthorization Requirements**

  Due to the increased demand for Inpatient and Outpatient Services for COVID-19 patients, many health care providers are shifting staff resources from administrative functions to direct patient care. This change in provider staffing resources requires that the Plan Administrator and its sub-subcontractor, while continuing to follow its normal procedures, may, at some point, find it necessary to suspend Preauthorization Review for Inpatient and Outpatient Services during the duration of the COVID-19 Pandemic as determined by the Chief Medical Officer of the State of Alaska. However, in such instances where suspension of Preauthorization Requirements is initiated all health care providers should use their best efforts to provide notice to the Plan Administrator's sub-subcontractor as soon as reasonably possible, including information necessary for them to assist in coordinating care and discharge planning.

- **Suspension of Concurrent Review for Inpatient Hospital Services**

  It is also understood that during the period of the COVID-19 Pandemic hospitals may lack the staffing resources to respond to Utilization Review requests for Concurrent Review while responding to the surge in-patient admissions. Therefore, while the Plan Administrator and its sub-subcontractor will continue to follow its normal procedures, from time to time, during the duration of the COVID-19 Pandemic, it may become necessary to suspend Concurrent Review for inpatient hospital services.

- **Suspension of Retrospective Review for Inpatient Services, Outpatient Services, Emergency Services, and Payment of Claims**

  It is also understood that during the period of the COVID-19 Pandemic Health Care providers may lack the staffing resources to respond to Utilization Review requests for Retrospective Review while responding to the surge in-patient admissions. Therefore, while the Plan Administrator and its sub-subcontractor will continue to follow its normal procedures, during the duration of the COVID-19 Pandemic, it may become necessary to

suspend Retrospective Review for Inpatient and Outpatient Services, and Emergency Services.

The Plan Administrator and its sub-contractor may request information to perform a Retrospective Review, reconcile claims, and make any payment adjustments after June 1, 2020, subject to further evaluation as the COVID-19 situation develops.

- **Suspension of Preauthorization Requirements for Post-Acute Placements**

  It is also understood that during the period of the COVID-19 Pandemic, health care providers may lack the staffing resources to respond to Preauthorization Requirements for Post-Acute Placements while responding to the surge of in-patient admissions. Therefore, while the Plan Administrator and it's sub-contractor will continue to follow its normal procedures, from time to time, during the duration of the COVID-19 Pandemic in order to permit hospitals to discharge patients to lower levels of care when medically appropriate, the Plan Administrator and its sub-contractor may suspend Preauthorization Requirements for Post-Acute Placements, including but not limited to, Skilled Nursing Facilities, Home Health Care Services, Acute Rehabilitation Services, and Long-Term Acute Care Hospitals, following an inpatient hospital admission.

- **Waiver of Credentialing by Location for Payers**

  It is also understood that during the period of the COVID-19 Pandemic, Health Care providers may lack the staffing resources to respond to prompt Credentialing by Location of Payers while responding to the surge of inpatient admissions. Therefore, while The Plan Administrator and its sub-contractor will attempt to continue to follow its normal procedures, during the duration of the COVID-19 Pandemic, it may become necessary to waive the normal requirements for Location-Based Credentialing. This will allow providers to see patients in a variety of locations.

Due to the evolving nature of the COVID-19 Pandemic outbreak, the State of Alaska deemed that it's directions are subject to change, and that Insurers and self-funded plan administrators are advised to verify best practices in accordance with the Centers for Disease Control and Prevention (CDC), and that the voluntary compliance of the State of Alaska are in effect until June 1, 2020, unless otherwise updated by the State of Alaska.

10.2 Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief and Economic Security Act (CARES)

The following services will be provided for the condition of Covid-19. These services will be paid at 100% of PPO contracted rate and/or provider's cash price, as listed by the provider on a public website, or a lower negotiated price. There will be no prior authorization or medical management requirements for these services.

- **Approval of Covid-19 diagnostic testing shall include:**

  tests for which a developer has requested, or intends to request, emergency use authorization from the FDA (until the request is denied or the developer does not submit a request within a reasonable timeframe),

  tests that are developed in and authorized by a State, or

  tests that the Secretary of Health and Human Services (HHS) deems appropriate.

- **Diagnostic Testing:**

  Items and services furnished to an individual during health care provider office visits (in-person and telehealth), urgent care center visits, and emergency room visits that result in an order or administration of the COVID-19 diagnostic testing, but only to the extent that such items and services relate to the furnishing of the COVID-19 diagnostic testing or to the evaluation of such individual for purposes of determining the need for COVID-19 diagnostic testing. This includes the examination of the person.

- **Preventive Services and Vaccines**

  Qualifying coronavirus preventive services including an item, service or immunization that is intended to prevent or mitigate COVID-19 and that is:

  an evidenced based item or service that has in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force or

  an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

  This requirement will take effect fifteen (15) business days after the date such recommendations may be made by the U.S. Preventive Services Task Force, or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention during the period of this Covid-19 Pandemic.

- **Inpatient Hospital Quarantines**. There may be times when Participants with the virus need to be quarantined in a Hospital private room to avoid infecting other individuals. These patients may not meet the need for acute inpatient care any longer but may remain in the Hospital for public health reasons. Such charges will not be denied solely because otherwise-applicable Medically Necessary requirements would not indicate a need for a private room.

- **Telehealth and Other Communication-Based Technology Services.** Participants can communicate with their doctors or certain other practitioners without going to the doctor's office in person. This is recommended if a Participant believes he or she has COVID-19 symptoms.

- **Requests for Prescription Refills.** When considering whether to cover a greater-than-30-day-supply of drugs, the Plan and its Prescription Drug Plan Administrator will, on a case-by-case, basis, consider each request and make decisions based on the circumstances of the patient.

- **Non-Emergency Ambulance Transportation**. The Plan will cover limited, Medically Necessary, non-emergency ambulance transportation relating to COVID-19 Diagnosis or treatment

10.3 Employer Continuation Coverage

Eligible Participants may seek to continue coverage upon the occurrence of any of the following:

- Layoff.

- Americans with Disabilities Act (ADA) Leave; A non-FMLA leave granted by the Employer in accordance with the ADA: coverage will continue.

- Leave of Absence (not meeting the definition of FMLA Leave).

- COVID-19 Leave. Leave taken in accordance with the Families First Coronavirus Response Act "FFCRA," including the Emergency Family and Medical Leave Expansion Act (see the Plan's "Continuation During Family and Medical Leave Act (FMLA)" section) and Emergency Paid Sick Leave Act: coverage will continue for the duration of the permitted leave under the FFCRA.

The above-noted leave(s) do not run concurrently with FMLA, USERRA, or any state-mandated family or medical leave, and/or any other applicable leaves of absence, as applicable and subject to applicable law. At the end of the period(s) listed above, the Participant's coverage will be deemed to have terminated for purposes of Continuation of Coverage under COBRA.

10.4 Until the end of the Outbreak Period of Covid-19 the Continuation During FMLA Leave section, the following provision will be added:

- FFCRA

  The Families First Coronavirus Response Act (FFCRA) requires certain employers to provide their employees with paid sick leave and expanded family and medical leave for specified reasons related to COVID-19. These provisions will apply from April 1, 2020 through December 31, 2020. Eligibility will be extended through any such leave in the same manner as for traditional FMLA leave.

- Eligible Employees

  In general, employees of private sector employers with fewer than 500 employees, and certain public sector employers, are eligible for up to two weeks of fully or partially paid sick leave for COVID-19 related reasons (see below). Employees who have been employed for at least 30 days prior to their leave request may be eligible for up to an additional 10 weeks of partially paid expanded family and medical leave for reason #5 below.

- Qualifying Reasons For Leave Related To COVID-19

  An employee is entitled to take leave related to COVID-19 if the employee is unable to work, including unable to telework, because the employee:

  - is subject to a Federal, State, or local quarantine or isolation order related to COVID-19;

  - has been advised by a health care provider to self-quarantine related to COVID-19;

  - is experiencing COVID-19 symptoms and is seeking a medical diagnosis;

  - is caring for an individual subject to an order described in (1) or self-quarantine as described in (2);

  - is caring for his or her child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons; or

  - is experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services.

- Tolling of Certain Plan Deadlines Due To COVID-19 RELIEF

  In accordance with 85 FR 26351, "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak," notwithstanding any existing Plan language to the contrary, the Plan will disregard the period from March 1, 2020 until sixty (60) days after (1) the end of the National emergency relating to COVID-19 and declared pursuant to 42 U.S.C. § 247d & 5121 et seq. or (2) such other date announced by the Departments of Treasury and/or Labor, for purposes of determining the following periods and dates:

  - The 30-day period (or 60-day period, if applicable) to request special enrollment under ERISA section 701(f) and Internal Revenue Code section 9801(f);
  - The 60-day election period for COBRA continuation coverage under ERISA section 605 and Internal Revenue Code section 4980B(f)(5);
  - The date for making COBRA premium payments pursuant to ERISA section 602(2)(C) and (3) and Internal Revenue Code section 4980B(f)(2)(B)(iii) and (C);
  - The date for individuals to notify the Plan of a qualifying event or determination of disability under ERISA section 606(a)(3) and Internal Revenue Code section 4980B(f)(6)(C);
  - The date within which individuals may file a benefit claim under the Plan's claims procedure pursuant to 29 CFR 2560.503-1;
  - The date within which Claimants may file an appeal of an Adverse Benefit Determination under the Plan's claims procedure pursuant to 29 CFR 2560.503-1(h);
  - The date within which Claimants may file a request for an external review after receipt of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination pursuant to 29 CFR 2590.715-2719(d)(2)(i) and 26 CFR 54.9815-2719(d)(2)(i); and
  - The date within which a Claimant may file information to perfect a request for external review upon a finding that the request was not complete pursuant to 29 CFR 2590.715-2719(d)(2)(ii) and 26 CFR 54.9815-2719(d)(2)(ii).

This period may also be disregarded in determining the applicable date for the Plan's duty to provide a COBRA election notice under ERISA section 606(c) and Internal Revenue Code section 4980B(f)(6)(D), however, note that the Plan intends to continue follow all established COBRA parameters.

These benefits will remain in effect until the Secretary of HHS determines that the public health emergency has expired.

11 MEDICAL LIMITATIONS AND EXCLUSIONS

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

11.1 Abortion

Elective abortion, unless the mother's life would be endangered if the Pregnancy were allowed to continue to term.

NOTE: Complications arising out of an abortion are covered as any other Sickness.

11.2 Adoption Expenses

Adoption expenses or any expenses related to surrogate parenting.

11.3 Alcohol or Drug-Related Injury or Sickness

Treatment of a Covered Person for an injury that occurs as a result of the Covered Person's illegal use of alcohol or as a result of voluntary taking or being under the influence of any controlled substance (drug, hallucinogen or narcotic) not administered on the advice of a Physician.

NOTE: Expenses of an injured Covered Person other than the person illegally using alcohol or controlled substances will not be affected by this exclusion. Also, this exclusion will not apply where such injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence.

11.4 Biofeedback

Biofeedback (except for the treatment of tension and migraine headaches), recreational, or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing.

11.5 Cosmetic & Reconstructive Surgery

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

- services necessitated by an Accidental Injury if treatment begins within ninety (90) days of the accident and then limited to care provided within twenty-four (24) months of the accident;
- reconstructive surgery that is incidental to or follows an Accidental Injury or Sickness, provided the surgery is not performed mainly to improve the mental or emotional state of the patient;
- surgical correction of a congenital abnormality (birth defect) that impairs a child's bodily function;
- coverage required by the Women's Health and Cancer Rights Act (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including lymphedemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient;

11.6 Custodial & Maintenance Care

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

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

11.7 Dental & Oral Care
Care or treatment on or to the teeth, alveolar processes, gingival tissue, or for malocclusion.

NOTE: This exclusion will not apply to Hospital expenses that are required for a dental procedure because of a concurrent hazardous medical condition such as serious blood dyscrasia, unstable diabetes or severe cardiovascular disease. Such dental procedures include but are not limited to: multiple extractions, removal of unerupted teeth, vestibuloplasty, and alveolectomy under general anesthesia. See the **Dental Benefit Summary** and related sections for dentist expenses.

11.8 Diagnostic Hospital Admissions
Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting.

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

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

Training of a Covered Person for the development of skills needed to cope with an Accidental Injury or Sickness, except as may be expressly included.

Non-medical self-help programs such as “Outward Bound” or “Wilderness Survival.”

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

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

- trimming or treatment of toenails;
- foot massage;
- treatment of corns, calluses, metatarsalgia or bunions;
- treatment of weak, strained, flat, unstable or unbalanced feet;
- impression casting for appliances or foot orthotics;
- orthopedic shoes (except when permanently attached to braces) or other appliances for support of the feet.

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

11.13 Genetic Counseling or Testing
Counseling or testing concerning inherited (genetic) disorders. However, this limitation does not apply when such services are determined to be Medically Necessary.

11.14 Hair Restoration
Any surgeries, treatments, drugs, services or supplies relating to baldness or hair loss, whether or not prescribed by a Physician.

11.15 Holistic, Homeopathic or Naturopathic Medicine
Services, supplies, drugs or accommodations provided in connection with holistic, homeopathic or naturopathic treatment.

11.16 Hypnotherapy
Treatment by hypnotism.

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

11.18 Infertility Testing or Treatment
Diagnostic tests or studies, or procedures, drugs or supplies to correct infertility or to restore or enhance fertility.

11.19 Learning & Behavioral Disorders
Testing or treatment for learning or behavioral disorders including dyslexia, attention deficit disorder (ADD), attention deficit hyperactive disorder (ADHD), mental retardation, autism, tongue thrust, stuttering or stammering, or other speech and articulation disorders.

11.20 Maintenance Care
See “Custodial & Maintenance Care”

11.21 Marriage & Family Counseling
Counseling for marital or family problems.

11.22 Massage Therapy
Massage therapy, except when performed by a Physician or Physical Therapist.

11.23 Nicotine Addiction
See “Smoking Cessation”

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

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

11.25 Not Medically Necessary / Not Physician Prescribed
Any services or supplies that are: (1) not Medically Necessary, and (2) not incurred on the advice of a Physician - unless expressly included herein.

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

Hospitalization ordered solely due to the patient's age, apprehension or emotional state, or for the convenience of the patient's family or Physician.

11.26 Orthognathic Surgery
Surgery to correct discrepancies in the relationship of the jaws.

NOTE: This exclusion will not apply when orthognathic surgery is required due to an Accidental Injury.

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

11.28 Preventive or Routine Care
Routine exams, physicals or anything not ordered by a Physician or not Medically Necessary for treatment of Sickness, Accidental Injury or Pregnancy, except as may be specifically included in the **Medical Benefit Summary**.

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

11.30 Sex-Related Disorders
Transsexualism, gender dysphoria, sexual reassignment or change, or other sexual dysfunctions or inadequacies. Excluded services and supplies include, but are not limited to: Physician exams, diagnostic laboratory or X-ray studies, therapy or counseling, medications, implants, hormone therapy, surgery, and other medical or psychiatric treatment.

11.31 Sleep Disorders
Diagnosis and treatment of sleep disorders. "Sleep disorders" include insomnia, narcolepsy, sleep apnea and parasomnias.

11.32 Smoking Cessation
Smoking cessation programs or any other services or supplies intended to assist an individual to quit smoking.

11.33 Vaccinations
Immunizations or vaccinations other than: (1) those included within the "Preventive Care" coverages (see the **Medical Benefit Summary**), and (2) tetanus or rabies vaccinations administered in connection with an Accidental Injury.

11.34 Vision Care
Eye exams for the purpose of determining refractive error and/or prescribing corrective lenses.

Vision supplies (e.g., eyeglasses or contact lenses) or their fitting, replacement, repair or adjustment.

Orthoptics, vision therapy, vision perception training, or other special vision procedures, including procedures whose purpose is the correction of refractive error, such as radial keratotomy or laser surgery.

NOTE: This exclusion will not apply to: (1) services necessitated by a Sickness or Accidental Injury, (2) the initial purchase of glasses or contact lenses following cataract surgery, or (3) aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

11.35 Vitamins or Dietary Supplements
Prescription or non-prescription organic substances used for nutritional purposes, except for pre-natal vitamins prescribed by a Physician. **Vocational Testing or Training** - Vocational testing, evaluation, counseling or training.

11.36 Weight Control
Weight control or obesity, including dietary control programs, surgery or complications of such surgery, wiring of the jaw, and procedures of similar nature, regardless of any contributing or subsequent medical condition or illness.

11.37 Wigs or Wig Maintenance
See "Hair Restoration".

- (See also General Exclusions section) –

12 PRESCRIPTION BENEFIT SUMMARY

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

Prescription coverage includes a retail program with participating retail pharmacies and a mail order pharmacy. A "participating pharmacy" has a contract with the prescription program vendor to dispense drugs to Plan participants.

Table 12.1: Schedule of Prescription Benefits	
Prescription Program	**Covered Person Pays**
Retail Pharmacy Feature (DAW - see Note)	
Generic Drug	$10 Co-Pay
Preferred Brand Drug	$20 Co-Pay
Non-Preferred Brand Drug	20% Co-Pay
To use the Retail Pharmacy Feature, a Covered Person takes his drug ID card to a participating pharmacy to fill his prescription order. A retail prescription can be purchased in up to a 100-day (3-month) supply. A Covered Person will be required to pay a separate Co-Pay for each month's supply.	
Mail Order Pharmacy (DAW – see Note)	No Co-Pay
The Mail Order pharmacy is for maintenance (longer-term) drugs. A mail order prescription can be purchased in up to a 100-day supply. It is mandatory that members order maintenance medications through mail order. However, the initial maintenance prescription may be filled at a local retail pharmacy with a Co-Pay.	

NOTE: "DAW" means that the pharmacist will dispense a prescription to the Covered Person based on the doctor's orders.

12.1 Over The Counter (OTC) Prilosec

The Plan will also offer coverage for Prilosec OTC. Covered Persons who choose to utilize Prilosec OTC, will only pay a generic Co-Pay.

12.2 Medicare Part D Creditable Coverage

If you are Medicare-eligible, you should be aware that Medicare offers prescription drug coverage (known as Medicare Part D). You are not required to choose this coverage. The Plan will continue to provide your prescription drug coverage if you become eligible for Medicare. If you enroll in coverage under this Plan and under Medicare Part D, you will be paying more for additional insurance that you may not need as Medicare Part D will not supplement your coverage under this Plan. There is no coordination between the plans. Prescription drug coverage under this Plan is, on average, at least as good as Medicare prescription drug coverage; therefore, there is no advantage to signing up for Medicare Part D coverage. The government refers to this as "creditable coverage". Since the Plan's coverage is considered to be creditable, you will not be subject to penalties or restrictions if you later choose to enroll in a Medicare prescription drug plan.

13 DESCRIPTION OF DENTAL BENEFITS

Table 13.1: Dental Benefit Summary		
Calendar Year Maximum Benefit	**$1,500**	
Plan benefits for each Covered Person will not exceed the maximum shown above.		
ELIGIBLE DENTAL EXPENSES	**Covered Person Pays**	**Plan Pays**
Preventive & Basic Services – See NOTES		
First Calendar Year (or partial year) of coverage	30%	70%
Second Calendar Year	20%	80%
Third Calendar Year	10%	90%
Fourth and Subsequent Calendar Years	0	100%
Limits applicable to certain Preventive Services: Routine oral exams and cleanings are limited to 2 exams/cleanings per Calendar Year; Fluoride treatment is limited to children under age 15 and to 2 applications per Calendar Year; Rebasing or relining of a denture is limited to once per 2 year period; Root canal treatment on the same tooth is limited to once per 2 year period; Sealants are limited to children under age 19 and to once per 5 year period per tooth; A routine full-mouth X-ray series or a panoramic X-ray is limited to once per 24 month period; Routine bitewing X-rays are limited to 2 sets per Calendar Year. NOTES: A Covered Person must have a dental exam each Calendar Year in order to move to the next higher benefit percentage. If a Covered Person does not have an exam in any one year or does not follow treatment recommendations by the dentist, the benefit percentage will reduce by 10%, but will not reduce to less than 70%. If a Covered Person is a "late enrollee" (see "Open Enrollment" in the Eligibility and Effective Dates section), dental benefits will not be available until the Covered Person has been enrolled for 12 consecutive months. However, the 12 month wait will not apply to dental treatment necessitated by an Accidental Injury.		
Major Services	**50%**	**50%**
If a Covered Person is a "late enrollee" (see "Open Enrollment" in the Eligibility and Effective Dates section), dental benefits will not be available until the Covered Person has been enrolled for 12 consecutive months. However, the 12 month wait will not apply to dental treatment necessitated by an Accidental Injury.		

THIS IS A SUMMARY ONLY. PLEASE REFER TO THE **ELIGIBLE DENTAL EXPENSES** AND **DENTAL LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION.

14 DENTAL PRE-TREATMENT ESTIMATE

If extensive dental work is needed (i.e., where the proposed course of treatment will cost more than $500), it is recommended that a pre-treatment estimate be obtained prior to the work being performed. Emergency treatments, oral examinations including prophylaxis, and dental X-rays will be considered part of the "extensive dental work" but may be performed before the pre-treatment estimate is obtained.

A pre-treatment estimate is obtained by having the attending dentist complete a statement listing the proposed dental work and charges. The form is then submitted to the Contract Administrator for review and estimate of benefits. The Contract Administrator may require an oral exam (at Plan expense) or request X-rays or additional information during the course of its review.

A pre-treatment estimate serves two purposes. First, it gives the patient and the dentist a good idea of benefit levels, (e.g., maximums, limitations) that might apply to the treatment program so that the patient's portion of the cost will be known and, secondly, it offers the patient and dentist an opportunity to consider other avenues of restorative care that might be equally satisfactory and less costly.

Most dentists are familiar with pre-treatment estimate procedures and the dental claim form is designed to facilitate pre-treatment estimates.

If a pre-treatment estimate is not obtained prior to the work being performed, the Plan Sponsor reserves the right to determine Plan benefits as if a pre-treatment estimate had been obtained.

NOTE: A pre-treatment estimate is not a guarantee of payment. Payment of Plan benefits is subject to Plan provisions and eligibility at the time the expenses are actually incurred.

15 ELIGIBLE DENTAL EXPENSES

Eligible dental expenses are the Usual, Customary and Reasonable charges for the dental services and supplies that are listed below and that are: (1) incurred while a person is covered hereunder, and (2) received from a licensed dentist, a qualified technician working under a dentist's supervision or any Physician furnishing dental services for which he is licensed.

For benefit purposes, dental expenses will be deemed incurred as follows:

for an appliance or modification of an appliance, on the date on which the appliance is seated;

for a crown, bridge or cast restoration, on the date the restoration is seated;

for root canal therapy, on the date the pulp chamber is opened; or

for any other service or supply, on the date the service is rendered or the supply is furnished.

NOTE: Many dental conditions can be effectively treated in more than one way. The Plan is designed to help pay for dental expenses, but not for treatment that is more expensive than necessary for good dental care. If a Covered Person chooses a more expensive course of treatment, the Plan will pay benefits equivalent to the least expensive treatment that would adequately correct the dental condition.

15.1 Preventive & Basic Services

Anesthesia

General anesthesia when administered in connection with oral surgery, major periodontal procedures, fractures or dislocations.

NOTE: Separate charges for pre-medication, local anesthesia, analgesia or conscious sedation are not covered. Such services may be included in the cost of the procedure itself.

Antibiotics

Antibiotics administered by a dentist or Physician.

Endodontia

Endodontic services including but not limited to: root canal therapy (except for final restoration), pulpotomy, apicoectomy and retrograde filling.

Exams & Cleanings, Routine

Routine oral examinations and routine cleaning and polishing of the teeth.

Extraction

See "Oral Surgery".

Fillings, Non-Precious

Amalgam, synthetic, porcelain and plastic restorations, including pins to retain a filling restoration when necessary.

Fluoride

Topical application of stannous or sodium fluoride.

Oral Surgery

Extraction of teeth, including simple extractions and surgical extraction of bone or tissue-impacted teeth. Other surgical and adjunctive treatment of disease, injury and defects of the oral cavity and associated structures.

Pathology

Laboratory services required for dental procedures.

Palliatives

Emergency treatment for the relief of dental pain.

Periodontia

Treatment of the gums and tissues of the mouth, including periodontal charting, scaling and root planning, gingival curettage, periodontal maintenance procedures, gingivectomy or gingivoplasty, osseous surgery, and mucogingival surgery.

Prophylaxis

See "Exams & Cleanings, Routine."

Repairs, Rebasing

Repairs or recementing of bridges, crowns or inlays. Rebasing or relining of removable dentures

Sealants

Application of sealants to the pits and fissures of the teeth, with the intent to seal the teeth and reduce the incidence of decay. Coverage is limited to application on the occlusal (biting) surface of permanent molars that are free of decay or prior restoration.

Space Maintainers

Fixed and removable appliances to retain the space left by a prematurely lost primary or "baby" tooth and to prevent abnormal movement of the surrounding teeth.

X-rays

Dental X-rays for diagnostic purposes, as well as routine “full mouth” X-rays or a panoramic X-ray, and routine bitewing X-rays.

15.2 Major Services
Crowns

Initial placement of a crown restoration when a tooth cannot be satisfactorily restored with a filling restoration. Coverage for a crown includes a post and core when necessary.

Replacement of a crown, if the existing crown is at least five (5) years old and cannot be made serviceable.

See "Cosmetic Dentistry" in the list of Dental Limitations and Exclusions for restrictions on veneer or facing (i.e., "tooth-colored") restorations. Crowns placed for periodontal splinting are not covered.

Inlays, Onlays, Foil & Gold Fillings

Initial placement of an inlay, onlay, foil or gold filling when a tooth cannot be satisfactorily restored with a less costly filling (e.g., amalgam) restoration.

Replacement of an inlay, onlay, foil or gold restoration, if the existing restoration is at least five (5) years old and cannot be made serviceable.

See "Cosmetic Dentistry" in the list of Dental Limitations and Exclusions for restrictions on "tooth-colored" restorations.

Prosthetics

Initial placement of a full or partial denture or bridge to replace one or more natural teeth that are extracted while the person is covered hereunder or while the person was covered under another dental benefit sponsored by the Employer. Any allowance made for a prosthetic includes necessary adjustments within six (6) months of placement.

Installation of precision attachments for removable dentures.

Addition of clasps or rests to an existing partial removable denture.

Replacement of or addition of teeth to an existing full or partial denture or bridge, but only if:

- the existing denture or bridgework cannot be made serviceable and is at least five (5) years old; or
- the existing denture is an immediate temporary denture to replace one (1) or more natural teeth and replacement by a permanent denture is required and takes place within twelve (12) months from the date of the initial installation of the immediate temporary denture.

16 DENTAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated, no benefits will be payable under this Plan for:

16.1 Appliances
Items intended for sport or home use, such as athletic mouth guards, night guards, occlusal splints or habit-breaking appliances.

16.2 Congenital Conditions
Treatment of congenital (hereditary) conditions (e.g. congenitally missing teeth), unless expressly included.

16.3 Cosmetic Dentistry
Treatment rendered for cosmetic or aesthetic purposes including, but not limited to: laminates, restorations due to misalignment, or discoloration of teeth (e.g., bleaching).

16.4 Discoloration Treatment
Teeth whitening or any other treatment to remove or lessen discoloration, except in connection with endodontia.

16.5 Excess Care
Services that exceed those necessary to achieve an acceptable level of dental care. If it is determined that alternative procedures, services, or courses of treatment could be (could have been) performed to correct a dental condition, Plan benefits will be limited to the least costly procedure(s) that would produce a professionally satisfactory result.

Duplicate prosthetic devices or appliances.

16.6 Experimental & Non-Standard Procedures
Services or supplies which do not meet the standards accepted by the American Dental Association (ADA) or by the Council of Dental Therapeutics of the American Dental Association.

16.7 Grafting
Extra oral grafts (grafting of tissue from outside the mouth to oral tissues).

16.8 Hospital Expenses

16.9 Implants
Implants (materials implanted into or on bone or soft tissue to support a crown or prosthetic, including services and supplies necessary for their installation), or the removal of implants.

16.10 Lost or Stolen Prosthetics or Appliances
Replacement of a prosthetic or any other type of appliance that has been lost, misplaced, or stolen.

16.11 Medical Expenses
Any dental-related services to the extent to which coverage is provided under the terms of the medical benefits of this Plan. That is, if benefits are available for the same expenses under both the medical and dental provisions of this document, such expense will first be considered for payment as medical expenses, and any remaining eligible balance will be considered for payment under these dental benefits. There will be no duplication of benefits.

16.12 Myofunctional Therapy
Muscle training therapy or training to correct or control harmful habits.

16.13 Non-Professional Care
Services rendered by someone other than:

- a dentist (DDS or DMD);
- a dental hygienist, X-ray technician or other qualified technician who is under the supervision of a dentist; or
- a Physician furnishing dental services for which he is licensed.

16.14 Occlusal Restoration
Procedures, appliances or restorations that are performed to alter, restore or maintain occlusion (i.e., the way the teeth mesh), including:

- increasing the vertical dimension;
- replacing or stabilizing tooth structure lost by attrition;
- realignment of teeth;
- gnathological recording or bite registration or bite analysis;
- occlusal equilibration.

16.15 Oral Hygiene Instruction & Supplies
Dietary or nutritional counseling or related supplies, personal oral hygiene instruction or plaque control. Oral hygiene supplies including but not limited to: toothpaste, toothbrushes, waterpiks, and mouthwashes.

16.16 Orthodontia
Orthodontia procedures (except tooth extraction), or appliances or restorations used to increase vertical dimension or to restore occlusion.

16.17 Orthognathic Surgery
Surgery to correct discrepancies in the relationship of the jaws, regardless of whether related to illness or injury.

16.18 Personalization or Characterization of Dentures

16.19 Prescription Drugs
See "Prescription Drugs, Outpatient" in the **Prescription Benefit Summary**

16.20 Prior to Effective Date / After Termination Date
Courses of treatment that began prior to the person's effective date of coverage, including crowns, bridges or dentures that were ordered prior to the effective date.

Expenses incurred after termination of coverage, except that benefits will be extended for up to thirty (30) days for the following:

- an appliance, or modification of an appliance when the impression was taken prior to the date of termination;

- a crown, inlay, onlay or gold restoration when the tooth was prepared prior to the date of termination;

- root canal therapy when the pulp chamber was opened prior to the date of termination.

16.21 Splinting
Appliances or restorations for splinting teeth.

16.22 Study Models

16.23 Temporary Restorations & Appliances
Excess charges for temporary restorations and appliances. Expenses for the permanent restoration or appliance will be the maximum Eligible Expense.

16.24 TMJ Treatment / Jaw Surgery
Procedures, restorations or appliances for the treatment or for the prevention of temporomandibular joint dysfunction syndrome.

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

17 DESCRIPTION OF VISION BENEFIT SUMMARY

The Plan will provide benefits, up to the amounts shown at the far right, for the vision services and supplies that are listed below. There is no Deductible requirement. Vision services or supplies must be rendered or ordered by a licensed ophthalmologist or optometrist.

Table 17.1: Summary of Vision Benefits		
Eligible Vision Expenses	**Covered Person Pays**	**Plan Pays**
Eye Exam	20%	80%
Limited to 1 exam per Calendar Year. Routines eye exams required by an employer as a condition of employment are not covered.		
Contacts		
Contact Lenses (in lieu of glasses, including disposables)	20%	80%
Subnormal (Medically Necessary) Contacts	0	100%
Limited to 1 pair of traditional contacts or a 12-month supply of disposable contacts per Calendar Year.		
Benefits for Medically Necessary contacts are limited to $400 per Lifetime. "Medically Necessary" contacts are those required: (1) when visual acuity cannot be improved to at least the 20/40 level in the better eye by use of standard glasses, (2) for keratoconus when vision is not correctable to 20/30 in either or both eyes using standard glasses, or (3) for high ametropia or anisometropia.		
Lenses for Glasses (in lieu of contacts)	20%	80%
Limited to 1 pair per Calendar Year.		
Frames	Expenses over $45	Up to $45
Limited to 1 frame per 2-Calendar Year period.		

THIS IS ONLY A SUMMARY. SEE THE **VISION LIMITATIONS AND EXCLUSIONS** SECTION FOR MORE INFORMATION.

18 VISION LIMITATIONS AND EXCLUSIONS

Except as expressly stated below, no vision benefits will be provided for:

18.1 Cosmetic Supplies
Oversize lenses, two pairs of glasses in lieu of bifocals, etc.

18.2 Medical or Surgical Treatment of the Eye
Medical or surgical treatment of the eye, including surgery to correct refractive error or placement of artificial eyes, including prescription-type.

18.3 Orthoptics
Services or supplies in connection with orthoptics, vision training or other special procedures.

18.4 Non-Prescription Lenses
Lenses that do not correct refractive error (plano lenses) or that are not obtained upon prescription by an ophthalmologist, optometrist or optician.

18.5 Replacement
Replacement of lenses, frames or contacts due to loss, theft or breakage. However, this limitation will not apply if the individual has been continuously covered hereunder for at least three (3) years and has not received benefits for these vision care supplies for at least three (3) years.

18.6 Safety Goggles

18.7 Sunglasses
Sunglasses (tint other than No. 1 or 2) or excess charges for photosensitive lenses.

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

19 GENERAL EXCLUSIONS

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

19.1 Court-Ordered Care

Treatment that is court-ordered or related to deferred prosecution, deferred or suspended sentencing or driving rights.

19.2 Criminal Activities

Any injury or illness resulting from or occurring during a Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation. This exclusion includes conditions which occur as a result of a Covered Person's illegal use of alcohol or of being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. An arresting officer's determination of inebriation will be sufficient for this exclusion.

Treatment rendered to inmates while in the custody (in jail or in prison) of any state or federal law enforcement authority.

NOTE: This exclusion does not apply to injury suffered by a victim of domestic violence.

19.3 Drugs in Testing Phases

Medicines or drugs that are in the Food and Drug Administration Phases I, II, or III testing, drugs that are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

19.4 Excess Charges

Charges in excess of the Usual, Customary and Reasonable fees for services or supplies provided. Costs for services or supplies that exceed those necessary to produce an acceptable result.

19.5 Experimental / Investigational Treatment

Expenses for treatments, procedures, devices, or drugs which the Plan determines, in the exercise of its discretion, are experimental, investigational, or done primarily for research or any services or supplies not considered legal in the United States Treatments, procedures, devices, or drugs shall be excluded hereunder unless:

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

"Reliable evidence" shall include anything determined to be such by the Plan, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature

generally considered to be authoritative by the medical professional community in the United States, including the *CMS Medicare Coverage Issues Manual*.

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

19.7 Government-Operated Facilities
Services furnished to the Covered Person in any veterans hospital, military hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments.

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

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

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

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

Hospital confinement, medical or surgical services or other treatment furnished or paid for by or on behalf of the United States or any state, province or other political subdivision, unless there is an unconditional requirement to pay such expenses whether or not there is insurance.

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

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

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

Expenses payable under any automobile medical, personal injury protection, automobile no-fault, homeowner, commercial premises coverage or similar contract of insurance when such contract or insurance is issued to or make benefits available to the Covered Person. This also includes treatment for sickness or injury for which a third party is liable,

Expenses for which benefits are available or provided by any other program sponsored by Kuspuk School District.

19.12 Outside United States / Canada
Charges incurred outside of the United States or Canada unless the Covered Person is a resident of the United States or Canada and the charges are incurred while traveling on business or extended vacation.

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

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

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

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

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

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

19.19 Telecommunications
Advice or consultation given by or through any form of telecommunication.

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

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

19.22 Work-Related Conditions
Any condition for which the Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose, whether or

not a claim is made for such benefits. If the Plan provides benefits for any such condition, the Plan Sponsor will be entitled to establish a lien upon such other benefits up to the amount paid.

20 COORDINATION OF BENEFITS (COB)

All health care benefits provided hereunder are subject to Coordination of Benefits as described below, unless specifically stated otherwise.

20.1 Definitions

As used in this COB section, the following terms will be capitalized and will have the meanings indicated:

Other Plan - Any of the following that provides health care benefits or services:

- group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured) toward the cost of which an employer make contributions or for which an employer makes payroll deductions; or
- Medicare or other governmental or tax-supported benefits, as permitted by law.

An "Other Plan" includes benefits that are actually paid or payable or benefits that would have been paid or payable if a claim had been properly made for them.

If an Other Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

NOTE: An "Other Plan" does not include benefits available from a Plan of liability insurance, property insurance, casualty insurance or property/casualty insurance including, but not limited to: a motor vehicle plan, a homeowner's plan, a renter's insurance plan or a boat owner's plan. This Plan will pay excess benefits ONLY to any such coverage.

This Plan - The health benefits that are described in this Benefit Document.

Allowable Expense -A health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans (i.e., This Plan or Other Plan(s)) covering the Claimant. When a plan provides benefits in the form of services (an HMO, for example), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

Claim Determination Period - A period that commences each January 1 and ends at 12 o'clock midnight on the next succeeding December 31, or that portion of such period during which the Claimant is covered under This Plan. The Claim Determination Period is the period during which This Plan's normal liability is determined (see "Effect on Benefits Under This Plan").

Custodial Parent - A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

20.2 Effect On Benefits Under This Plan

When Other Plan Does Not Contain a COB Provision -If an Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be "primary" and This Plan will pay its benefits AFTER such Other Plan(s). This Plan's liability will be the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

When Other Plan Contains a COB Provision - When an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the "Order of

Benefit Determination Rules" below. If, in accordance with those rules, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits AFTER an Other Plan(s), it will pay the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

NOTE: The determination of This Plan's "normal liability" will be made for an entire Claim Determination Period (i.e. Calendar Year). If this Plan is "secondary", the difference between the benefit payments that This Plan would have paid had it been the primary Plan and the benefit payments that it actually pays as a secondary Plan is recorded as a "benefit reserve" for the Covered Person and will be used to pay Allowable Expenses not otherwise paid during the balance of the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero.

20.3 Order of Benefit Determination Rules

Whether This Plan is the "primary" Plan or a "secondary" Plan is determined in accordance with the following rules.

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

Medicare as an "Other Plan" - Medicare will be the primary, secondary or last payer in accordance with federal law. When Medicare is the primary payer, This Plan will determine its benefits based on Medicare Part A, Part B and Part D benefits that would have been paid or payable, regardless of whether or not the person was enrolled for such benefits.

NOTE: An active Employee (or spouse) age 65 or older who is eligible for Medicare and who chooses to have Medicare as their primary carrier, may not also have coverage hereunder.

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

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

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

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

- the Plan of the Custodial Parent;
- the Plan of the spouse of the Custodial Parent;
- the Plan of the noncustodial parent; and then
- the Plan of the spouse of the noncustodial parent.

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

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

Continuation Coverage (COBRA) Enrollee - If a Claimant is a COBRA enrollee under This Plan, an Other Plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary and This Plan is secondary. If the Other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

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

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

20.4 Other Information About Coordination of Benefits

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

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

Right of Recovery - If the amount of the payments made by the Plan is more than it should have paid under this COB section, the Plan may recover the excess from one or more of the persons it has paid or for whom it has paid - or any other person or organization that may be responsible for the benefits or services provided for the Claimant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

21 SUBROGATION AND REIMBURSEMENT PROVISIONS

21.1 Payment Condition

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

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

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

21.2 Subrogation

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

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

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

If the Covered Person(s) fails to file a claim or pursue damages against:

- the responsible party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;

- worker's compensation or other liability insurance company; or
- any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

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

21.3 Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the 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 subrogation lien. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

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

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the 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.

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).

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.

21.4 Excess Insurance

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

- the responsible party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;

- worker's compensation or other liability insurance company; or

- any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

21.5 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.

21.6 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.

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

- to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

- to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;

- to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

- to do nothing to prejudice the Plan's rights of subrogation and reimbursement;

- to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

- to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

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

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

21.8 Offset
Failure by the Covered Person(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical

benefits and any funds or payments due under this Plan may be withheld until the Covered Person(s) satisfies his or her obligation.

21.9 Minor Status

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.

21.10 Language Interpretation

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

21.11 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.

22 ELIGIBILITY AND EFFECTIVE DATES

22.1 Eligibility Requirements - Employees

To participate as an Employee in the Plan coverages that are described herein, an individual must be:

a resident of the United States;

in permanent, full-time active employment for the Employer and performing all customary duties of his occupation at his usual place of employment (or at a location to which the business of the Employer requires him to travel); and

regularly scheduled to work for the Employer at least five (5) or more hours per day or an average of twenty-five (25) hours per week.

After continuous service with the Employer for five (5) full years (or 5 full school terms for a seasonal Employee), an individual with a work schedule of fewer than five (5) hours per day is eligible for the same coverages as a permanent full-time Employee.

An Employee will be deemed in "active employment" on each day he is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day. An Employee will also be deemed in "active employment" on any day on which he is absent from work during an approved FMLA leave or solely due to his own health status (see "Non-Discrimination Due to Health Status" in the **General Plan Information** section). An exception applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on his first scheduled workday, he will not be considered as having commenced active employment.

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

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

22.2 Effective Date - Employees

All district employees are eligible for group life and health insurance coverage the first day of permanent employment.

Except as noted, if an Employee fails to enroll within thirty-one (31) days of becoming eligible, his coverage can become effective only in accordance with the :Open Enrollment" or "Special Enrollment Rights" provision below.

NOTE: If an Employee declines coverage for himself or his eligible Dependents because of coverage under another group plan or other insurance, he is required to sign the waiver of coverage portion of the enrollment application. He must identify such coverage. If the waiver of coverage is not signed, the Employee and his Dependents will not be entitled to the "Special Enrollment Right" due to loss of other coverage.

22.3 Eligibility Requirements - Dependents

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

a legally married spouse. A "spouse" will mean a person of the opposite sex (i.e., not the same sex as the Employee). "Married" means a legal union as determined in accordance with the federal

Defense of Marriage Act (DOMA) between one man and one woman as husband and wife and will not include a common law spouse;

a child under age 26 who is:

a natural child;

a stepchild;

a child under the Employee's legal guardianship;

a child who is in the physical custody of and is under the Employee's temporary guardianship provided such guardianship is approved by the Tribal Council and is in accordance with the rules and terms of the Native Village of Upper Kaskag;

a child who is adopted by the Employee or placed with him for adoption prior to age 18. "Placed for adoption" means the assumption and retention by the Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have begun. Placement ends when the legal support obligation ends; or

notwithstanding any residency or main support and care requirements, a child for whom Plan coverage is required due to a Medical Child Support Order (MCSO) that the Plan Sponsor determines to be a Qualified Medical Child Support Order in accordance with its written procedures (that are incorporated herein by reference and that can be obtained without charge). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and that satisfies the QMCSO requirements. A child whose coverage is subject to a court order need not be a Tax Code dependent of an Employee;

NOTES: An eligible Dependent does not include:

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

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

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

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

22.4 Effective Date - Dependents

A Dependent who is eligible and enrolled when the Employee enrolls, will have coverage effective on the same date as the Employee. Dependents acquired later may be enrolled within thirty-one (31) days of their eligibility date. See the "Special Enrollment Rights" provision for additional details as well as instances when the loss of other coverage and other circumstances can allow a Dependent to be enrolled. Otherwise, a Dependent can be enrolled only in accordance with the "Open Enrollment" provision.

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

22.5 Newborn – Automatic Coverage

A newborn child is automatically covered if the Employee has family coverage in effect on the child's date of birth. Otherwise, the newborn must be enrolled in accordance with the "Special Enrollment Rights" or "Open Enrollment" provisions, below.

22.6 Special Enrollment Rights & Mid-Year Election Change Allowances

Entitlement to Enroll Due to Loss of Other Coverage - An individual who did not enroll in the Plan when previously eligible, will be allowed to apply for coverage hereunder at a later date if:

he was covered under another group health Plan or other health insurance coverage (including Medicaid) at the time coverage was initially offered or previously available to him. "Health insurance coverage" means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;

the Employee stated in writing at the time a prior enrollment was offered or available that other coverage was the reason for declining enrollment in the Plan. However, this only applies if the Plan Sponsor required such a written statement and provided the person with notice of the requirement and the consequences of failure to comply with the requirement;

the individual lost the other coverage as a result of a certain event and the Employee requested Plan enrollment within thirty (30) days of termination of the other coverage (and, on or after April 1, 2009, within sixty (60) days with regard to Medicaid or CHIP - see last sub-entry below). A loss of coverage event includes but is not limited to:

> loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment;
>
> loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual);
>
> loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
>
> loss of eligibility when an individual incurs a claim that would meet or exceed a lifetime limit on all benefits. An individual has a special enrollment right when a claim that would exceed a lifetime limit on all benefits is incurred, and the right continues at least until thirty (30) days after the earliest date that a claim is denied due to the operation of the lifetime limit;
>
> loss of eligibility when a Plan no longer offers any benefits to a class of similarly situated individuals. For example, if a Plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility, even if the Plan continues to provide coverage to other employees;

loss of eligibility when employer contributions toward the employee's or dependent's coverage terminates. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer;

loss of eligibility when COBRA continuation coverage is exhausted; and

on or after April 1, 2009, loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP) or the date the individual becomes eligible for State premium assistance under Medicaid or CHIP.

If the above conditions are met, Plan coverage will be effective on the first day of the first calendar month that begins after the date on which the Plan received the completed application.

NOTES: For a Dependent to enroll under the terms of this provision, the Employee must be enrolled or must enroll concurrently.

Loss of other coverage for failure to pay premiums on a timely basis or for cause (e.g., making a fraudulent claim or making an intentional misrepresentation of a material fact with respect to the other coverage) will not be a valid loss of coverage for these purposes.

Entitlement to Drop Due to CHIP Eligibility – If an Employee's child(ren) become eligible for CHIP, Employee has the ability to drop the child(ren) from the group health coverage.

Entitlement Due to Acquiring New Dependent(s) - If an Employee acquires one (1) or more new eligible Dependents through marriage, birth, adoption, or placement for adoption (as defined by Federal law), application for their coverage may be made within thirty-one (31) days of the date the new Dependent or Dependents are acquired (the "triggering event") and Plan coverage will be effective as follows - see NOTE:

where Employee's marriage is the "triggering event" - the spouse's coverage (and the coverage of any eligible Dependent children the Employee acquires in the marriage) will be effective on the first day of the first calendar month that begins after the date on which the Plan received the completed application;

where acquisition of a child is the "triggering event" - the child's coverage will be effective on the date of the event (i.e., concurrent with the child's date of birth, date of placement or date of adoption). The "triggering event" date for a newborn adoptive child is the child's date of birth if the child is placed with the Employee within 31 days of birth.

NOTES: For a newly-acquired Dependent to be enrolled under the terms of this provision, the Employee must be enrolled or must be eligible to enroll (i.e., must have satisfied any waiting period requirement) and must enroll concurrently. If the newly-acquired Dependent is a child, the spouse is also eligible to enroll. However, other Dependent children who were not enrolled when first eligible are not considered to be newly acquired and can only be enrolled in accordance with other enrollment allowances hereunder.

Court or Agency Ordered Coverage - If an Employee or an Employee's spouse is required to provide coverage for a child under a Medical Child Support Order, coverage for the child shall be effective as of the date specified in such order provided that such order is qualified according to the Plan Sponsor's written procedures and provided that a request for coverage is made on a form acceptable to the Plan Sponsor within 31 days from the date such order is determined to be

qualified (QMCSO). A request to enroll the child may be made by the Employee, the Employee's spouse, the child's other parent, or by a State Agency on the child's behalf.

If the Employee is not enrolled when the Plan is presented with an MCSO that is determined to be qualified, and the Employee's enrollment is required in order to enroll the child, both must be enrolled. The Employer is entitled to withhold any applicable payroll contributions for coverage from the Employee's pay.

22.7 Open Enrollment

If an individual does not enroll when he is first eligible to do so or if he allows coverage to lapse, he may later enroll during an Open Enrollment period that will be held annually. Plan coverage will be effective on the first of the month following the end of the Open Enrollment period.

22.8 Reinstatement / Rehire

Rehired Employees who were previously retired must be provided the same eligibility for coverage as a new hire per the revised unified law of the State of Alaska (AS.14.20.135).

If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA), and during the leave Employee discontinued paying his share of the cost of coverage, such Employee may have coverage reinstated as if there had been no lapse (for himself and any Dependents who were covered at the point contributions ceased). To avoid interruption of coverage during the leave, the Plan Sponsor will have the right to keep coverage in force at its own expense and can require that unpaid coverage contribution costs be repaid by the Employee at the end of the FMLA leave.

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

If an Employee returns to an eligible status after having experienced a "Qualifying Event" and having continued Plan coverage, without interruption, as a "Qualified Beneficiary" under the terms of the **COBRA Continuation Coverage**, such person and Dependents will be reinstated to active status and will have uninterrupted coverage hereunder. That is, a new waiting period requirement will not be applied and the Plan's preexisting condition limits will apply only to the extent they may have applied upon discontinuance of COBRA coverage.

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

Benefits for any Employee or Dependent who is covered hereunder, whose employment or coverage is terminated, and who is subsequently rehired or reinstated at any time, shall be limited to the maximum benefits that would have been payable had there been no interruption of employment or coverage.

22.9 Transfer of Coverage

If a husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of his eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such transferred coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase

any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

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

23 RESCISSION OF COVERAGE

The following provisions will apply to the Plan regarding rescission of coverage:

- A "rescission" is a cancellation or discontinuance of coverage that has a retroactive effect.
- A cancellation or discontinuation of coverage is not a rescission if it only has a prospective effect, or the retroactive effect is attributable to failure to timely pay required premiums or contributions.
- The Plan can rescind coverage if an individual is involved in fraud or intentional misrepresentation.
- The Plan will provide at least 30 days advance notice to each participant who would be affected before coverage may be rescinded.

24 TERMINATION OF COVERAGE

24.1 Employee Coverage Termination

Except as noted, an Employee's coverage will terminate upon the earliest of the following:

- termination of the Plan or Plan benefits as described herein;
- Employee's termination of participation in the Plan or these Plan benefits;
- at the end of the period for which Employee last made the required contribution, if the coverage is provided on a contributory basis (i.e. Employee shares in the cost);
- at midnight on the last day of the month in which the covered Employee leaves or is dismissed from the employment of the Employer, ceases to be eligible, or ceases to be engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the **Extensions of Coverage** section;
- the date the Employee dies.

See also "Termination for Fraud" at the end of the **General Plan Information** section.

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

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

24.2 Dependent Coverage Termination

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

- termination of the Plan or these Plan benefits or discontinuance of Dependent coverage hereunder;
- termination of the coverage of the Employee,
- at midnight on the last day of the month in which the Dependent ceases to meet the eligibility requirements of these Plan benefits, except when coverage is extended under the **Extensions of Coverage** section. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee;
- on the date the Employee requests that Dependent coverage be terminated or at the end of the period for which the Employee last made the required contribution for such coverage, if Dependent's coverage is provided on a contributory basis (i.e., Employee shares in the cost). However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has comparable replacement coverage that is in effect or will take effect immediately upon termination.

See also "Termination for Fraud" at the end of the **General Plan Information** section.

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

- (See COBRA Continuation Coverage) –

25 EXTENSIONS OF COVERAGE

Coverage may be continued beyond the **Termination of Coverage** date in the circumstances identified below. Unless expressly stated otherwise, however, coverage will not extend: (1) beyond the date the Plan is terminated, and (2) for a Dependent, beyond the date the Employee's coverage ceases.

25.1 Extension of Coverage for Disabled Children

If an unmarried child is age 19 or over and is incapable of self-sustaining employment by reason of a mental or physical handicap, then such child's eligibility may be extended. The Employee must provide proof of the child's incapacity and dependency within thirty-one (31) days of the date the child attains age 19 or the date coverage would have terminated due to the child's failure to maintain student status. Thereafter, continuing proof of incapacity may be required at reasonable intervals.

25.2 Extensions of Coverage During Absence From Work

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

Except where the Family and Medical Leave Act (FMLA) may apply, any coverage which is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

- on the date coverage terminates as specified in the Employer's personnel policies or other employee communications, if any. Such documents are incorporated herein by reference;
- the end of the period for which the last contribution was paid, if such contribution is required;
- the date of termination of the Plan or these benefits of the Plan.

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

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

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

- the birth of an Employee's child and in order to care for the child;
- the placement of a child with the Employee for adoption or foster care;

- to care for a spouse, child or parent of the Employee where such relative has a serious health condition;

- Employee's own serious health condition that makes him/her unable to perform the functions of his or her job;

- the Employee has a "qualifying exigency" (as defined by DOL regulations) arising because the Employee's spouse, son, daughter or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation (a specified military operation).

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. The above is a summary of FMLA requirements. An Employee can obtain a more complete description of his FMLA rights from the Plan Sponsor's Human Resources or Personnel department. Any Plan provisions which are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

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

25.3 Extension of Coverage During U.S. Military Service

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

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

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

If the Employee provides the Employer with advance notice of his military service but fails to elect continuation of coverage under USERRA, the Plan Administrator will continue coverage for the first thirty (30) days after Employee's departure from employment due to active military service.

The Plan Administrator will terminate coverage if Employee's notice to elect coverage is not received by the end of the 30-day period. If the Employee subsequently elects to continue coverage while on active military service and within the time set forth in the subsection entitled "Maximum Period of Coverage" below, then the Employee will be retroactively reinstated in the Plan as of the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premium charges from the date Plan coverage terminated.

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

Maximum Period of Coverage – The maximum period of USERRA continuation coverage following Employee's cessation of active employment is the lesser of:

- 24 months; or
- the duration of Employee's active military service.

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

The Employee must return to employment:

- on the first full business day following completion of military service for military leave of 30 days or less; or
- within 14 days of completion of military service for military leave of 31-180 days; or
- within 90 days of completion of military service for military leave of more than 180 days.

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

- (See COBRA Continuation Coverage) -

26 CLAIMS PROCEDURES

26.1 Submitting A Claim

A claim is a request for a benefit determination that is made, in accordance with the Plan's procedures, by a Claimant or his authorized representative. A claim must name the Plan, a specific Claimant, a specific health condition or symptom or diagnostic code, and a specific treatment, service or supply (or procedure/revenue codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services are received, and provider name, address, phone number and tax identification number.

There are two types of health claims: (1) Pre-Service Claims, and (2) Post-Service Claims:

1) **A Pre-Service Claim** is where the terms of the Plan condition benefits, in whole or in part, on prior approval of the proposed care. See the **Utilization Management Program** section for that information.

Important: A Pre-Service Claim is only for the purposes of assessing the Medical Necessity and appropriateness of care and delivery setting. A determination on a Pre-Service Claim is not a guarantee of benefits from the Plan. Plan benefit payments are subject to review upon submission of a claim to the Plan after medical services have been received, and are subject to all related Plan provisions, including exclusions and limitations.

2) **A Post-Service Claim** is a written request for benefit determination after a service has been rendered and expense has been incurred. A Post-Service Claim must be submitted to the claims office within thirty (30) days of the first expense for which benefits arising out of an injury or illness may be claimed, or thereafter as is reasonably possible. However, when an individual's coverage terminates for any reason, written proof of claim must be provided within ninety (90) days of the termination of coverage, if the Plan remains in force. Upon termination of the Plan or these benefits of the Plan, final claims must be received within thirty (30) days of termination.

In no event will any claim be considered or payment if it is presented more than six (6) months from the date that such expense was incurred.

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

26.2 Assignments To Providers

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

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

In the event the Plan fails to pay benefits to a provider in respect of a claim incurred by a Covered Person, the Employee or Covered Person will be responsible for paying the provider any amounts due for the services received.

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

NOTE: Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or his beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable hereunder.

26.3 Claims Time Limits And Allowances

The chart below sets forth the time limits and allowances that apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (e.g., how quickly the Plan must respond to claims notices, filings and claims appeals and how much time is allowed for Claimants to respond). If there is any variance between the following information and the intended requirements of the law, the law will prevail.

Important: These claims procedures address the periods within which claims determinations must be decided, not paid. Benefit payments must be made within reasonable periods following Plan approval.

Table 26.1: Claim Time Limits

"PRE-SERVICE" CLAIM ACTIVITY	**TIME LIMIT OR ALLOWANCE**
Urgent Claim - defined below	
Claimant Makes Initial Incomplete Claim Request	Within not more than 24 hours (and as soon as possible considering the urgency of the medical situation), Plan notifies Claimant of information needed to complete the claim request. Notification may be oral unless Claimant requests a written notice.
Plan Receives Completing Information	Plan notifies Claimant, in writing or electronically, of its benefit determination as soon as possible and not later than 48 hours after the earlier of: (1) receipt of the completing information, or (2) the period of time Claimant was allowed to provide the completing

	information.
Claimant Makes Initial Complete Claim Request	Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), Plan responds with written or electronic benefit determination.
Claimant Appeals	See "Appeal Procedures" subsection. An appeal for an urgent claim may be made orally or in writing.
Plan Responds to Appeal	Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), after receipt of Claimant's appeal.
An "urgent claim" is an oral or written request for benefit determination where the decision would result in either of the following if decided within the time frames for non-urgent claims: (1) serious jeopardy to the Claimant's life or health, or the ability to regain maximum function, or (2) in the judgment of a Physician knowledgeable about the Claimant's condition, severe pain that could not be adequately managed without the care or treatment being claimed.	
Where the "Time Limit or Allowance" stated above reflects "or sooner if possible," this phrase means that an earlier response may be required, considering the urgency of the medical situation.	
Concurrent Care Claim - defined below	
Plan Wants to Reduce or Terminate Already Approved Care	Plan notifies Claimant of intent to reduce or deny benefits before any reduction or termination of benefits is made and provides enough time to allow the Claimant to appeal and obtain a response to the appeal before the benefit is reduced or terminated. Any decision with the potential of causing disruption to ongoing care that is Medically Necessary, is subject to the urgent claim rules.
Claimant Requests Extension for Urgent Care	Plan notifies Claimant of its benefit determination within 24 hours after receipt of the request (and as soon as possible considering the urgency of the medical situation), provided the Claimant requests to extend the course of treatment at least 24 hours prior to the expiration of the previously-approved period of time or treatment.
A "concurrent care claim" is a Claimant's request to extend a previously-approved and ongoing course of treatment beyond the approved period of time or number of treatments. A decision to reduce or terminate benefits already approved does not include a benefit reduction or denial due to Plan amendment or termination.	

Non-Urgent Claim	
Claimant Makes Initial Incomplete Claim Request	Within 5 days of receipt of the incomplete claim request, Plan notifies Claimant, orally or in writing, of information needed to complete the claim request. Claimant may request a written notification.
Plan Receives Completing Information	Plan responds with written or electronic benefit determination within 15 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Makes Initial Complete Claim Request	Within 15 days, Plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to Claimant -see definition of "full notice" below
Claimant Appeals	See "Appeal Procedures" subsection.
Plan Responds to Appeal	Within 30 days after receipt of appeal (or where Plan requires 2 mandatory levels of appeal, within 15 days for each appeal).
"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 15-day period.	
"POST-SERVICE" CLAIM ACTIVITY	**TIME LIMIT OR ALLOWANCE**
Claimant Makes Initial Incomplete Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request.
Plan Receives Completing Information	Plan approves or denies claim within 30 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Makes Initial Complete Claim Request	Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Appeals	See "Appeals Procedures" subsection.

Plan Responds to Appeal	Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels).
"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period.	

26.4 Authorized Representative May Act for Claimant

Any of the above actions that can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf. The Claimant may be required to provide reasonable proof of such authorization. For an urgent claim, a health care professional, with knowledge of a Claimant's medical condition, will be permitted to act as the authorized representative of the Claimant. "Health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

26.5 Written or Electronic Notices

The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial. Written or electronic notice of an approved benefit must be provided only for Pre-Service benefit determinations.

26.6 Claims Denials

If a claim is wholly or partially denied, the Claimant will be given written or electronic notification of such denial within the time frames required by law - see "Claims Time Limits and Allowances." The notice will include the following and will be provided in a manner intended to be understood by the Claimant:

the specific reason(s) for the decision to reduce or deny benefits:

specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols that were relied upon in making the decision;

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

a description of any additional information needed to change the decision and an explanation of why it is needed;

a description of the Plan's procedures and time limits for appealed claims.

26.7 Appeal Procedures

Filing an Appeal

Within 180 days of receiving notice of a claim reduction or denial, a Claimant may appeal his claim, in writing, to a new decision-maker and he may submit new information (e.g. comments, documents and records) in support of his appeal. A Claimant may not take legal action on a denied claim until he has exhausted the Plan's mandatory (i.e., non-voluntary) appeal procedures - see NOTE.

In response to his appeal, the Claimant is entitled to a full and fair review of the claim and a new decision. A "full and fair review" takes into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

At such time as the Claimant appeals a denied claim, he will be provided, upon request and free of charge, with access to and copies of all documents, records and other information relevant to his claim for benefits.

NOTE: In accordance with Federal law, the Plan cannot require more than two (2) levels of mandatory appeal. If more than one (1) level of mandatory appeal is required, both must be completed within the time frame applicable to one (1) level.

Decision on Appeal

A decision with regard to the claim appeal will be made within the allowed time frame - see "Claims Time Limits and Allowances."

The decision on appeal will be in writing or by electronic notification. If the decision is to continue to reduce or deny benefits, the notification will be provided in a manner calculated to be understood by the Claimant and will include:

the specific reason(s) for the decision;

reference to the pertinent Plan provisions on which the decision is based;

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 claim;

identification of and access to any guidelines, rules, protocols that were relied upon in making the decision;

a statement describing any voluntary appeal procedures offered by the Plan, the Claimant's right to obtain the information about such procedures.

A Plan participant and the Plan may have other voluntary alternative dispute resolutions options, such as mediation. One way to find out what may be available is to contact the Local U.S. Department of Labor Office and the State insurance regulatory agency.

27 DEFINITIONS

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

27.1 Accidental Injury

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

27.2 Ambulatory Surgical Center

Any public or private establishment that:

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

27.3 Benefit Document

A document that describes one (1) or more benefits of the Plan.

27.4 Birthing Center

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

- is in compliance with licensing and other legal requirements in the jurisdiction where it is located;
- is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients;
- have organized facilities for birth services on its premises;
- provides birth services by or under the direction of a Physician specializing in obstetrics and gynecology;
- has 24-hour-a-day registered nursing services;
- maintains daily clinical records.

27.5 Calendar Year

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

27.6 Claimant

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

27.7 Community Mental Health Agency
A health care provider which is licensed as a mental health agency by a state's Department of Social and Health Services or comparable state agency, which has in effect a plan for quality assurance, peer review and supervision by a Physician or licensed psychologist.

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

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

27.9 Convalescent Hospital
See "Skilled Nursing Facility".

27.10 Covered Person
An individual who meets the eligibility requirements as contained herein (e.g., a covered Employee, a covered Dependent, or a Qualified Beneficiary (COBRA)). See **Eligibility and Effective Dates, Extensions of Coverage** and the **COBRA Continuation Coverage** sections for further information.

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

27.11 Covered Provider
An individual who is:

licensed to perform certain health care services that are covered hereunder and who is acting within the scope of his license; or

in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association;

and who is a/an:

- Acupuncturist (CA)
- Audiologist
- Certified Consulting Psychologist
- Certified or Registered Nurse Midwife
- Certified Registered Nurse Anesthetist (CRNA)
- Chiropractor (DC)
- Dental Hygienist

- Dentist (DDS or DMD)
- Dietician
- Denturist
- Licensed Counselor (MSW, LCSW, MA, MFC, or LPC) under the direct supervision of a Physician and whose expenses are billed through that Physician)
- Licensed Practical Nurse (LPN)
- Marriage Family and Child Counselor (MFCC)
- Naturopath
- Nurse Practitioner
- Occupational Therapist (OTR)
- Optometrist (OD)
- Physical Therapist (PT or RPT)
- Physician - see definition of "Physician"
- Physician Assistant (PA)
- Podiatrist or Chiropodist (DPM, DSP, or DSC)
- Psychiatrist (MD)
- Registered Nurse (RN)
- Respiratory Therapist
- Speech Pathologist

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

- any practitioner of the healing arts who is licensed and regulated by a state or federal agency, is providing services or supplies that are covered hereunder, and is acting within the scope of his license;
- facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, Birthing Centers, clinics;
- licensed Outpatient mental health facilities;
- freestanding public health facilities;
- hemodialysis and Outpatient clinics under the direction of a Physician (MD);
- enuresis control centers;

- home infusion therapy providers;
- durable medical equipment providers;
- prosthetists and prosthetist-orthotists;
- portable X-ray companies;
- independent laboratories and lab technicians;
- diagnostic imaging facilities;
- blood banks;
- speech and hearing centers;
- ambulance companies.

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

27.12 Dependent
See Eligibility and Effective Dates section

27.13 Eligible Expense(s)
Expense that is: (1) covered by a specific benefit provision of the Benefit Document, and (2) incurred while the person is covered by the Plan.

27.14 Emergency
See "Medical Emergency".

27.15 Employee
See the **Eligibility and Effective Dates** section **Employer(s)** - The Employer or Employers participating in these Plan benefits as reflected in the **General Plan Information** section.

27.16 Fiduciary
An entity having binding power to make decisions regarding Plan policies, interpretations, practices or procedures.

27.17 Freestanding Chemical Dependency Treatment Center or Residential Treatment Facility
A facility that meets the following requirements:

- it is accredited by the Hospital Accreditation Program of the Joint Commission on the Accreditation of Hospitals or is licensed by the appropriate state licensing authority as a “Chemical Dependency Treatment Center”;
- it is operated chiefly for the treatment of chemical dependency;

- it provides only treatment which is directly under the supervision of a Physician; and

- it provides 24-hour nursing service by licensed nurses.

27.18 Home Health Care Agency
An agency or organization that:

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

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

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

- maintains a complete medical record on each patient;

- has a full-time administrator.

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

27.19 Hospice or Hospice Agency
An entity providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel that includes at least one Physician and one registered nurse, and must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

27.20 Hospital
An accredited institution that is approved as a Hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Health Care Organizations or the American Osteopathic Association, and that meets all of the following criteria:

- it is primarily engaged in providing, for compensation from its patients and on an Inpatient basis, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians. If primarily a facility for the treatment of mental health conditions or substance abuse, such facility must have a bonafide arrangement by contract or otherwise with a hospital to perform such surgical procedures as may be required:

- it continuously provides 24-hour-a-day nursing service by registered nurses under the supervision of Physicians; and

- it is not, other than incidentally, a place for rest, the aged, a nursing home, a hotel or the like.

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

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

27.23 Lifetime
All periods an individual is covered hereunder, including any prior statements of these benefits of the Plan. It does not mean a Covered Person's entire lifetime.

27.24 Medical Emergency
An Accidental Injury or the sudden onset of a medical condition, either of which is of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health or, with respect to a pregnancy, the health of the woman or her unborn child, in serious jeopardy, (2) serious impairment of bodily functions, or (3) serious dysfunction of any bodily organ or part.

27.25 Medically Necessary
Any health care treatment, service or supply determined by the Plan Administrator to meet each of the following requirements:

it is ordered by a Physician for the diagnosis or treatment of a Sickness or Accidental Injury;

the prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition;

it is furnished by a provider with appropriate training and experience, acting within the scope of his or her license; and

it is provided at the most appropriate level of care needed to treat the particular condition.

With respect to Inpatient services and supplies, "Medically Necessary" further means that the health condition requires a degree and frequency of services and treatment that can be provided ONLY on an Inpatient basis.

The Plan Administrator will determine whether the above requirements have been met based on: (1) published reports in authoritative medical and scientific literature, (2) regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration (FDA), and the Centers for Medicare and Medicaid Services (CMS), (3) listings in the following compendia: *The American Hospital Formulary Service Drug Information* and *The United States Pharmacopoeia Dispensing Information*; and (4) other

authoritative medical resources to the extent the Plan Administrator determines them to be necessary.

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

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

27.28 Physician
A legally licensed medical or dental doctor or surgeon, chiropractor, osteopath, podiatrist, certified consulting psychologist, psychiatrist or other licensed healthcare provider to the extent that same, within the scope of their license, are permitted to perform services provided in this Plan. The term "Physician" also includes a certified licensed nurse midwife, a nurse practitioner, licensed naturopath and a social worker with the degree "MSW".

NOTE: The term "Physician" will not include the Covered Person himself, his relatives (see **General Exclusions**) or interns, residents, fellows or others enrolled in a graduate medical education program.

27.29 Plan
The Plan of employee welfare benefits provided by the Plan Sponsor. The name of the Plan is shown in the **General Plan Information** section.

27.30 Plan Administrator
See "Plan Sponsor".

27.31 Plan Document
A formal written document that describes the Plan and the rights and responsibilities of the Plan Sponsor with regard to the Plan, including any amendments.

27.32 Plan Sponsor
The entity sponsoring the Plan. The Plan Sponsor may also be referred to as the Plan Administrator. See **General Plan Information** section for further information.

27.33 Pregnancy
Pre-natal and post-natal care during pregnancy, childbirth, miscarriage or complications arising therefrom. See "Pregnancy Care" in the list of **Eligible Medical Expenses** for further information.

27.34 Psychiatric (Mental Health) Treatment Facility
An administratively distinct governmental, public, private or independent unit or part of such unit that provides psychiatric services and care. Such facility:

- is at all times supervised by a staff of Physicians;
- provides at all times skilled nursing care by licensed nurses who are directed by a full-time RN;
- prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs that is supervised by a Physician;

- meets appropriate licensing standards.

27.35 Rehabilitation Facility
A legally operating institution or distinct part of an institution which has a transfer agreement with one or more hospitals, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, hospital and rehabilitative Inpatient care and is duly licensed by the appropriate government agency to provide such services.

A Rehabilitation Facility does not include institutions which provide only minimal care, custodial care, ambulatory or part-time care services, or an institution which primarily provides treatment of mental disorders, chemical dependency or tuberculosis, except if such facility is licensed, certified or approved as a rehabilitation facility for the treatment of medical conditions, drug addiction or alcoholism in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission on the Accreditation of Health Care Organizations or the Commission for the Accreditation on Rehabilitation Facilities.

27.36 Sickness
Bodily illness or disease (other than mental health conditions or chemical dependencies), congenital abnormalities, birth defects and premature birth. A condition must be diagnosed by a Physician in order to be considered a Sickness by this Plan.

27.37 Skilled Nursing Facility
An institution that:

- is duly licensed as a convalescent hospital, extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with the governing laws and regulations;
- is primarily engaged in providing accommodations and skilled nursing care 24-hours-a-day for convalescing persons;
- is under the full-time supervision of a Physician or a registered nurse;
- admits patients only upon the recommendation of a Physician, maintains complete medical records, and has available at all times the services of a Physician;
- has established methods and procedures for the dispensing and administering of drugs;
- has an effective utilization review plan;
- is approved and licensed by Medicare;
- has a written transfer agreement in effect with one or more Hospitals; and
- is not, other than incidentally, a nursing home, a hotel, a school or a similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

27.38 Substance Abuse Treatment Facility
An institution that:

- provides a program for diagnosis, evaluation and effective treatment of alcoholism and/or drug use or abuse;
- provides detoxification services, infirmary level medical services or arranges at a Hospital in the area for any other medical services that may be required;
- is at all times supervised by a staff of Physician;
- provides at all times skilled nursing care by licensed nurses who are directed by a full-time RN;
- prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs that are supervised by a Physician; and
- meets licensing standards.

27.39 Urgent Care Facility
A facility that is engaged primarily in providing minor emergency and episodic medical care and that has:

- a board-certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance at all times;
- X-ray and laboratory equipment and a life support system.
- An Urgent Care Facility may include a clinic located at, operated in conjunction with, or that is part of a regular Hospital.

27.40 Usual, Customary and Reasonable (UCR)
A charge made by a provider that does not exceed the general level of charges made by other providers in the area or community who have similar experience and training for the treatment of health conditions comparable in severity and nature to the health condition being treated. The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of the level of charges

With regard to charges made by a provider of service participating in the Plan's Network program, Usual, Customary and Reasonable will mean the provider's negotiated rate - but not to exceed the actual charge or the non-Network Usual, Customary and Reasonable allowance unless such lesser amount is not permitted under the terms of the Network agreement.

NOTES: UCR for multiple surgical procedures is determined as follows:

if bilateral or multiple surgical procedures that increase the time and amount of patient care are performed, UCR will be 100% of the UCR allowance for the primary procedure plus the lesser of 50% of the UCR allowance for each additional procedure or the actual fee charged;

if an incidental procedure is performed through the same incision, the Eligible Expense is the UCR allowance for the major surgical procedure only. Examples of incidental procedures are excision of a scar, appendectomy, etc.

If an assistant surgeon is required for a covered surgery, the assistant surgeon’s UCR allowance will not exceed 20% of the surgeon’s UCR allowance.

26.41 Women's Health and Cancer Rights Act (WHCRA)

The Women's Health and Cancer Rights Act of 1998, as amended. Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: 1) All stages of reconstruction of the breast on which the mastectomy was performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) Prostheses; and 4) Treatment of physical complications at all stages of mastectomy, including lymphedema.

28 ADMINISTRATIVE PROVISIONS

28.1 Administration (type of)

The Plan benefits described herein are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator. The Contract Administrator is not an insurance company.

28.2 Alternative Care

In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan Sponsor elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to provide benefits thereafter in strict accordance with the provisions of the Benefit Document.

28.3 Amendment or Termination of the Plan

Since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any participant or beneficiary:

reduce, modify or terminate retiree health care benefits hereunder, if any;

alter or postpone the method of payment of any benefit;

amend any provision of these administrative provisions;

make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code; and

terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those Plan benefits to which he has become entitled.

NOTE: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's board of directors, or by written amendment that is signed by at least one Fiduciary of the Plan. Employees will be provided with notice of the change within the time allowed by federal law.

28.4 Anticipation, Alienation, Sale or Transfer

Except for assignments to providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

28.5 Clerical Error
Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

28.6 Creditable Coverage Certificates
Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a "certificate of creditable coverage" or "certificate of group health Plan coverage," from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates (including termination due to exhaustion of all lifetime benefits under the Plan), the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

28.7 Discrepancies
In the event that there may be a discrepancy between any separate booklet(s) provided to Employees ("Summary Plan Descriptions") and the Benefit Document, the Benefit Document will prevail.

28.8 Facility of Payment
Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefor under the Plan.

28.9 Fiduciary Responsibility, Authority and Discretion
Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

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

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

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

28.10 Force Majeure
Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

28.11 Gender and Number
Except when otherwise indicated by the context, any masculine terminology will include the feminine (and vice-versa) and any term in the singular will include the plural (and vice-versa).

28.12 Illegality of Particular Provision
The illegality of any particular provision of the Benefit Document will not affect the other provisions and the Benefit Document will be construed in all respects as if such invalid provision were omitted.

28.13 Indemnification
To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

28.14 Legal Actions
No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Benefit Document and Plan Document.

No legal action may be brought to recover on the Plan: (1) more than three years from the time written proof of loss is required to be given, or (2) until the Plan's mandatory claim appeal(s) are exhausted. See the **Claims Procedures** section for more information.

28.15 Loss of Benefits
To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or beneficiary might otherwise reasonably expect the Plan to provide based on the description of benefits:

- an employee's cessation of active service for the employer;
- a Plan participant's failure to pay his share of the cost of coverage, if any, in a timely manner;
- a dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces);
- a Plan participant is injured and expenses for treatment may be paid by or recovered from a third party;
- a claim for benefits is not filed within the time limits of the Plan.

28.16 Material Modification
In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days.

"Material modifications" are those which would be construed by the average Plan participant as being "important" reductions in coverage and generally would include any Plan modification or change that: (1) eliminates or reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations, (2) increases premiums, deductibles, coinsurance, copays, or other amounts to be paid by a Plan participant or beneficiary, or (3) establishes new conditions or requirements (i.e., preauthorization requirements) to obtaining services or benefits under the Plan.

28.17 Misstatement / Misrepresentation
If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual in an

enrollment form or claims filing, his eligibility, benefits or both, will be adjusted to reflect his true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

28.18 Misuse of Identification Card

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

28.19 Non-Discrimination Due to Health Status

An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

- a medical condition (whether physical or mental and including conditions arising out of acts of domestic
- violence)
- claims experience
- receipt of health care
- medical history
- evidence of insurability
- disability
- genetic information

28.20 Physical Examination

The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

28.21 Plan Administrator Discretion & Authority

The Plan Administrator has the exclusive authority, in its sole and absolute discretion, to take any and all actions necessary to or appropriate to interpret the terms of the Plan in order to make all determinations thereunder. The Plan Sponsor shall make determinations regarding coverage and eligibility. The Plan Administrator (or the delegated Contract Administrator acting within the scope of its delegated authority on behalf of the Plan) shall make determinations regarding Plan benefits.

28.22 Privacy Rules & Security Standards & Intent to Comply

To the extent required by law, the Plan Sponsor certifies that the Plan will: (1) comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rules") of the Health Insurance Portability and Accountability Act (HIPAA) and (2) comply with HIPAA Security Standards with respect to electronic Protected Health Information.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

28.23 Purpose of the Plan

The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents.

Reimbursements

Plan's Right to Reimburse Another Party - Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Payment in Error - When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefor from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

28.24 Rights Against the Plan Sponsor or Employer

Neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

28.25 Termination for Fraud

An individual's Plan coverage or eligibility for coverage may be terminated if:

- the individual submits any claim that contains false or fraudulent elements under state or federal law;
- a civil or criminal court finds that the individual has submitted claims that contain false or fraudulent elements
- under state or federal law;
- an individual has submitted a claim that, in good faith judgment and investigation, he knew or should have known, contained false or fraudulent elements under state or federal law.

28.26 Titles or Headings

Where titles or headings precede explanatory text throughout the Benefit Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Benefit Document and will not affect the validity, construction or effect of the Benefit Document provisions.

28.27 Type of Plan

This Plan is not a plan of insurance. This Plan is a self-funded nonfederal governmental group health Plan that, for the most part, is exempt from the requirements of the Employee Retirement Income Security Act (ERISA). However, governmental plans are not automatically exempted from the following amendments to ERISA: The Health Insurance Portability and Accountability Act (HIPAA), the Newborns and Mothers Health Protection Act (NMHPA), and the Women's Health and Cancer Rights Act (WHCRA). To be exempt from certain requirements of these laws, the Plan must make an affirmative written election to be excluded. Such election must be filed with the Centers for Medicare and Medicaid Services (CMS) prior to the beginning of each Plan Year, with notice provided to each Plan participant. Unless such written election is filed and participant notices are made, this Plan intends to fully comply with the above-stated federal laws.

28.28 Workers' Compensation

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

29 STATEMENT OF RIGHTS OF EMPLOYEES

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

29.1 Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), if applicable, and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

29.2 Continue Group Health Plan Coverage

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

29.3 Prudent Actions by Plan Fiduciaries

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

29.4 Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the previously mentioned rights. For instance, if you request a copy of Plan documents (i.e., Summary Plan Descriptions and Summary of Material Modifications) or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If, after you exhaust your appeals, you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. Such suit must be filed within 180 days from the date of an adverse appeal determination notice. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries

misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

29.5 Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 1-866-444-3272.

30 COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, that is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent will prevail over this summary.

If a retired Employee is covered under the Plan and one of his Dependents has a Qualifying Event (e.g., divorce or loss of Dependent child eligibility), such Dependent may be eligible for COBRA Continuation Coverage. Also, certain other COBRA rights apply to such retirees and their covered Dependents with regard to an Employer's bankruptcy. Anywhere "retirees" are referenced herein; it means only those retired Employees who were covered under the Plan.

30.1 Definitions

When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary - An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee, or the covered Dependent spouse (as defined by the federal Defense of Marriage Act) or child of a covered Employee.

Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverages the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

Exception: An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which he was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

NOTE: COBRA Continuation Coverage rights do not apply to Dependents who do not meet the Section 152 Tax Code definition of a dependent (i.e., a "qualifying child" or a "qualifying relative").

Qualifying Event - Any of the following events that would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

- voluntary or involuntary termination of Employee's employment for any reason other than Employee's gross misconduct;

- reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his portion of the cost of Plan coverage during the FMLA leave;

- for an Employee's spouse or child, Employee's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that his or her Medicare coverage is in effect;

- for an Employee's spouse or child, the divorce or legal separation of the Employee and spouse;

- for an Employee's spouse or child, the death of the covered Employee;

- for an Employee's child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit);

- for retirees and their Dependent spouses and children, loss of Plan coverage due to the Employer's filing of a bankruptcy proceeding under Title 11 of the U.S. Bankruptcy Code. In order for a Qualifying Event to occur, the Employee must have retired on or before the date of substantial elimination of the Plan's benefits and must be covered under the Plan on the day before the bankruptcy proceedings begin. "Substantial elimination" of the Plan's benefits must occur within 12 months before or after the bankruptcy proceedings begin.

NonCOBRA Beneficiary - An individual who is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

30.2 Notification Responsibilities

If the Employer is the Plan Administrator and if the Qualifying Event is Employee's termination/reduction in hours, death, or Medicare entitlement, then the Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights, or the unavailability of COBRA rights, within 44 days of the event. If the Employer is not the Plan Administrator, then the Employer's notification to the Plan Administrator must occur within 30 days of the Qualifying Event and the Plan Administrator must provide Qualified Beneficiaries with their COBRA rights notice within 14 days thereafter. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

If COBRA continuation coverage terminates early (e.g., the Employer ceases to provide any group health coverage, a Qualified Beneficiary fails to pay a required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election), the Plan Administrator must provide the Qualified Beneficiary(ies) with notification of such early termination. Notice must include the reason for early termination, the date of termination and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred that permits him to exercise coverage

continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is a Dependent child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the Employee from his/her spouse. A Qualified Beneficiary is also responsible for other notifications. See the section entitled **COBRA Notice Requirements for Plan Participants** (and the Employer's "COBRA General Notice" or "Initial Notice") for further details and time limits imposed on such notifications. Upon receipt of a notice, the Plan Administrator must notify the Qualified Beneficiary(ies) of their continuation rights within 14 days.

30.3 Election and Election Period

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary. See NOTE.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Plan Administrator.

Open enrollment rights that allow NonCOBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

NOTE: See the "Effect of the Trade Act" provision for information regarding a second 60-day election period allowance.

30.4 Effective Date of Coverage
COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

30.5 Level of Benefits
COBRA continuation coverage will be equivalent to coverage provided to similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated NonCOBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to his deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health Plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

30.6 Cost of Continuation Coverage
The cost of COBRA continuation coverage will not exceed 102% of the Plan’s full cost of coverage during the same period for similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. The “full cost” includes any part of the cost that is paid by the Employer for NonCOBRA Beneficiaries. Qualified Beneficiaries can be charged up to 150% of the full cost for the 11-month disability extension period if the disabled person is among those extending coverage.

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Sponsor permits a billing grace period later than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Sponsor.

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase if:

- the cost previously charged was less than the maximum permitted by law;
- the increase is due to a rate increase at Plan renewal;
- the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law that is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or
- the Qualified Beneficiary changes his coverage option(s) that results in a different coverage cost.

Timely payments that are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least 30 days) to make full payment. A payment will be considered an "insignificant shortfall" if it is not greater than $50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTES: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically-indigent or due to a certain disability. The Employer's personnel offices should be contacted for additional information.

See the "Effect of the Trade Act" provision for additional cost of coverage information.

30.7 Maximum Coverage Periods

The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

- if the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the loss of coverage due to the Qualifying Event. With a disability extension (see "Disability Extension" information below), the 18 months is extended to 29 months;
- if the Qualifying Event occurs to a Dependent due to Employee's enrollment in the Medicare program before the Employee himself experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare;
- for any other Qualifying Event, the maximum coverage period ends 36 months after the loss of coverage due to the Qualifying Event.

If a Qualifying Event occurs that provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment will not expand the maximum

COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first Qualifying Event.

COBRA entitlement runs concurrently with continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) - USERRA does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

30.8 Disability Extension

An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to be disabled in the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date that falls within the allowable periods described. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his or her family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension himself.

30.9 Termination of Continuation Coverage

Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of loss of coverage due to the Qualifying Event and ending on the earliest of the following dates:

- the last day of the applicable maximum coverage period - see "Maximum Coverage Periods" above;
- the date on which the Employer ceases to provide any group health Plan to any Employee;
- the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any preexisting condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary;
- the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his or her Medicare coverage is in effect;
- in the case of a Qualified Beneficiary entitled to a disability extension, the later of:
    - 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination

under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

- the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;

- the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated NonCOBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

30.10 Effect of the Trade Act

In response to Public Law 107-210, referred to as the Trade Act of 2002 ("TAA"), the Plan is deemed to be "Qualified Health Insurance" pursuant to TAA, the Plan provides COBRA continuation of coverage in the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, as amended.

Eligible Individuals -The Plan Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation ("PBGC"), pursuant to TAA as of or after November 4, 2002. The Plan Administrator shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement or federal income tax filings. The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

Temporary Extension of COBRA Election Period

Definitions:

- Nonelecting TAA-Eligible Individual – A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA continuation coverage during the TAA-Related Election Period.

- TAA-Eligible Individual – An eligible TAA recipient and an eligible alternative TAA recipient.

- TAA-Related Election Period – with respect to a TAA-related loss of coverage, the 60-day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual.

- TAA-Related Loss of Coverage – means, with respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

In the case of an otherwise COBRA Qualified Beneficiary who is a Nonelecting TAA-Eligible Individual, such individual may elect COBRA continuation of coverage during the TAA-Related Election Period, but only if such election is made not later than six (6) months after the date of the TAA-Related Loss of Coverage.

Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period, and shall not include any period prior to the such individual's TAA-Related Election Period.

HIPAA Creditable Coverage Credit With respect to any TAA-Eligible Individual who elects COBRA continuation of coverage as a Nonelecting TAA Individual, the period beginning on the date the TAA-Related Loss of Coverage, and ending on the first day of the TAA-Related Election Period shall be disregarded for purposes of determining the 63-day break-in-coverage period pursuant to HIPAA rules regarding determination of prior creditable coverage for application to the Plan's preexisting condition exclusion provision.

Applicable Cost of Coverage Payments Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA-Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in IRS regulations 54.4980B-8, A-5(d), the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.

31 COBRA NOTICE REQUIREMENTS FOR PLAN PARTICIPANTS

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is:

- a Dependent child's ceasing to be eligible (e.g., due to reaching the maximum age limit);
- the divorce or legal separation of the Employee from his/her spouse;
- the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to **COBRA Continuation Coverage** with a maximum duration of 18 (or 29) months;
- where a Qualified Beneficiary entitled to receive **COBRA Continuation Coverage** with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled in the first 60 days of continuation coverage, or (b) a Qualified Beneficiary as described in "(a)" has subsequently been determined by the Social Security Administration to no longer be disabled

Notification must be made in accordance with the following procedures. Any individual who is either the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered 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.

Notification must be made in accordance with the following procedures. However, these procedures are current as of the date the document was prepared and a Qualified Beneficiary should make certain that procedure changes have not occurred before relying on this information. The most current information should be included in the Employer's COBRA Initial General Notice that is provided to new hires.

Any individual who is either the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered 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.

Form, Content & Delivery - Notification of the Qualifying Event must provided in writing and must be received by the Employer no later than the last day of the required notice period (see "Time Requirements for Notification" below).

Any notice provided must include: (1) the name of the Plan or Plans under which coverage has been or will be lost, (2) the name and address of the employee covered under the Plan(s), (3) the name(s) and address(es) of the Qualified Beneficiary(ies), and the type of Qualifying Event and the date it happened.

If the Qualifying Event is a divorce or legal separation, notice must include a copy of the divorce decree or legal separate agreement.

Time Requirements for Notification -In the case of a divorce, legal separation or a child losing dependent status, Notice must be delivered within 60 days from the later of: (1) the date of the Qualifying Event, (2) the date health plan coverage is lost due to the event, or

(3) the date the Qualified Beneficiary is notified of the obligation to provide Notice through the Summary Plan Description or the Plan Sponsor's General COBRA Notice. If Notice is not received within the 60-day period, **COBRA Continuation Coverage** will not be available, except in the case of a loss of coverage due to foreign competition where a second COBRA election period may be available – see "Effect of the Trade Act" in the **COBRA Continuation Coverage** section of the Plan's Summary Plan Description or Benefit Document.

If an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, Notice must be delivered within 60 days from the later of: (1) the date of the determination, (2) the date of the Qualifying event, (3) the date coverage is lost as a result of the Qualifying Event, or (4) the date the covered Employee or Qualified Beneficiary is advised of the Notice obligation through the SPD or the Plan Sponsor's General COBRA Notice. Notice must be provided within the 18-month COBRA coverage period. Any such Qualified Beneficiary must also provide Notice within 30 days of the date he is subsequently determined by the Social Security Administration to no longer be disabled.

The Plan will not reject an incomplete Notice as long as the Notice identifies the Plan, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete Notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following the request.

32 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) RIGHTS

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health Plans, and provide privacy rights to participants in those plans. This section provides an overview of those rights. You will receive from the Plan Administrator a separate "Notice of Privacy Provisions" which contains additional information about how your individually identifiable health information is protected and who you should contact with questions or concerns.

32.1 HIPAA Privacy

HIPAA applies to medical and prescription drug plans. These Plans are commonly referred to as "HIPAA Plans" and are administered to comply with the applicable provisions of HIPAA.

Protected Health Information (PHI) is information created or received by the HIPAA Plans that relates to an individual's physical or mental health or condition (including genetic information as provided under the Genetic Information Nondiscrimination Act), the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

The Plan will comply with all privacy requirements defined in the HIPAA Privacy Policy and will use or disclose PHI only if the use or disclosure is permitted or required by HIPAA Regulations and any other applicable Federal, state, or local law.

The HIPAA Plans may disclose PHI to the Plan sponsor only for limited purposes as defined in the HIPAA Privacy Rules. The Plan sponsor agrees to use and disclose PHI only as permitted or required by HIPAA. PHI may be used or disclosed for Plan administration functions that the Plan sponsor performs on behalf of the HIPAA Plans. Such functions include:

- enrollment of eligible individuals;
- eligibility determinations;
- payment for coverage;
- claim payment activities;
- coordination of benefits; and
- claim appeals.

If a Plan participant wants to exercise any of his or her rights concerning PHI, he or she should contact the specific Claims Administrator involved with the PHI in question. The Claims Administrator will advise the Plan participant of the procedures to be followed.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the Company or Plan sponsor with respect to such

information. The Company or Plan sponsor will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA Regulations.

Any HIPAA Plan will maintain policies and procedures that govern the HIPAA Plan's use and disclosure of PHI. These policies and procedures include provisions to restrict access solely to the previously listed positions/departments and only for the functions listed previously. The HIPAA Plan's policies and procedures will also include a mechanism for resolving issues of noncompliance.

In accordance with the Health Breach Notification Rule (16 CFR Part 18), the Plan sponsor agrees to notify both participants and the Federal Trade Commission of the use or disclosure of any PHI or electronic PHI provided for Plan Administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, of which the Plan sponsor or any Business Associate of the Plan sponsor becomes aware.

32.2 HIPAA Electronic Security Standards

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Plan documents must reflect certain obligations required of the Employer.

- The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

- The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

- The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in compliance with HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers.

32.3 Certificate of Creditable Coverage

HIPAA also requires that participants automatically receive a certificate of creditable coverage within a reasonable period of time after coverage ceases (if not eligible for COBRA continuation coverage) or after COBRA coverage ends (including any grace period for non-payment of COBRA premiums). For participants who are eligible to elect COBRA continuation coverage, the certificate will be provided no later than 44 days after a qualifying event (See Continuing Health Care Coverage through COBRA below.)

The standard certificate includes basic health Plan participation information and a statement as to whether you and your covered dependent(s) had at least 18 months of coverage without a significant break (more than 63 days). If you or your dependent(s) had less than 18 months of coverage, the statement will include the date coverage began and ended as well as the date of any waiting period.

To request another copy of the standard certificate and/or the alternative certificate, contact the Plan Administrator within 24 months after the end of a period of continuous coverage. Your certificate

will be sent in a reasonable and prompt fashion or, alternatively, if all parties agree, the Plan Administrator may provide this information by phone.

33 GENERAL PLAN INFORMATION

Table 33.1 General Plan Information	
Name of Plan	Kuspuk School District Employee Healthcare Plan
Plan Sponsor and Plan Administrator Address	Kuspuk School District P.O.Box 49 Aniak, AK 99557
Business Phone Number	(907)675-4250
Plan Sponsor ID Number (EIN)	92-0057610
Plan Number	501
Plan Year	July 1 through June 30
Type of Plan	Self-Funded Employee Benefit Plan
Claims Administrator	Integrity Administrators, Inc.
Address	1787 Tribute Road, Suite E P O Box 13128 Sacramento, CA 95813
Phone	916-921-3388
Statutory Agent for Service of Legal Process	The Plan Sponsor named above

KUSPUK SCHOOL DISTRICT
EMPLOYEE HEALTHCARE PLAN

ADMINISTERED BY

INTEGRITY ADMINISTRATORS, INC.
1787 TRIBUTE ROAD, SUITE E
SACRAMENTO, CA 95815

PO BOX 13128
SACRAMENTO, CA 95813-3128
(800) 562-9383 FAX (916) 921-3383