SAN FELIPE DEL RIO CISD
GROUP HEALTH PLAN

Plan Document and Summary Plan Description
Effective: January 1, 2022

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ARTICLE I
ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by **San Felipe Del Rio Consolidated Independent School District** (the "Company" or the "Plan Sponsor") as of January 1, 2022, hereby sets forth the provisions of the **San Felipe Del Rio CISD Group Health Plan** (the "Plan"). Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

1.01 Effective Date
The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein (the "Effective Date").

1.02 Adoption of the Plan Document
The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

San Felipe Del Rio Consolidated Independent School District

By: 

Name: Carlos H. Rios

Date: January 3, 2022 Title: Superintendent of Schools

ARTICLE II
INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

2.01 Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Plan benefits may be self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from Covered Persons and/or the Plan Sponsor, or may be funded solely from the general assets of the Plan Sponsor. Covered Persons in the Plan may be required to contribute toward their benefits.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for eligible Employees, the economic effects arising from a non-occupational Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by the Company and may be inspected at any time during normal working hours by any Covered Person.

2.02 General Plan Information

Name of Plan:	**San Felipe Del Rio CISD Group Health Plan**
Plan Sponsor (Company):	**San Felipe Del Rio Consolidated Independent School District** **315 Griner Street** **Del Rio, TX 78840** **Phone: 1-830-778-4014**
Plan Administrator: **(Named Fiduciary)**	**San Felipe Del Rio Consolidated Independent School District** **Chief Human Resources Officer** **315 Griner Street** **Del Rio, TX 78840** **Phone: 1-830-778-4014**
Plan Sponsor ID No. (EIN):	**74-1694073**
Source of Funding:	**Self-Funded**
Plan Status:	**Non-Grandfathered**
Applicable Law:	**State of Texas**
Plan Year:	**January 1 - December 31**
Fiscal Year:	**January 1 - December 31**
Plan Number:	**501**
Plan Type:	**Medical** **Prescription Drug**

Claims Administrator:	**The Kempton Group Administrators, Inc.** **13431 Broadway Ext., Suite 130** **Oklahoma City, OK 73114** **1-405-521-1711; 1-800-521-1711** **www.kemptongroup.com**
Participating Employer(s):	**San Felipe Del Rio Consolidated Independent School District** **315 Griner Street** **Del Rio, TX 78840** **Phone: 1-830-778-4014**
Agent for Service of Process:	**San Felipe Del Rio Consolidated Independent School District** **315 Griner Street** **Del Rio, TX 78840** **Phone: 1-830-778-4014**
Plan Trustee(s):	**A list of the Trustee(s) of the Plan, if any, including name, title and address, is available upon request to the Plan Administrator.**

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

2.03 Legal Entity; Service of Process
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

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

2.05 Applicable Law
This is a self-funded benefit plan. The Plan is funded with Employee and/or Employer contributions. When applicable, Federal law and jurisdiction preempt State law and jurisdiction.

2.06 Discretionary Authority
To the extent allowed by law, the Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Covered Person's rights; and to determine all questions of fact and law arising under the Plan.

2.07 Type of Administration
The Plan is a self-funded group health plan and the administration is provided through a Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

2.08 Non-English Language Notice
This Plan Document contains a summary in English of a Covered Person's plan rights and benefits under the Plan. If a Covered Person has difficulty understanding any part of this Plan Document, he or she may contact the Plan Administrator at the contact information above.

2.09 Nondiscrimination

No eligibility rules or variations in contribution amounts will be imposed based on an eligible Employee's and his or her Dependent's/Dependents' health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of an eligible Employee's and his or her Dependent's/Dependents' race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

2.10 Important Updates Regarding COVID-19 Relief – Tolling of Certain Plan Deadlines

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. § 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:

1. 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);
2. The 60-day election period for COBRA continuation coverage under ERISA section 605 and Internal Revenue Code section 4980B(f)(5);
3. 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);
4. 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);
5. The date within which individuals may file a benefit claim under the Plan's claims procedure pursuant to 29 CFR 2560.503-1;
6. 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);
7. 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
8. 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 to follow all established COBRA parameters.

In no instance will the duration of an extension granted under this section exceed one calendar year.

ARTICLE III
SCHEDULE OF BENEFITS

Covered Persons are encouraged to contact The Kempton Group Administrators, Inc. at 1-800-324-9396 for assistance in understanding the benefits below, for verification of eligibility, or for any general questions that may arise.

Your Identification Card lists the number and web site for you to call or go on line to verify eligibility for Plan benefits before a charge is Incurred.

Verification of Eligibility 1-800-324-9396 or online at www.kemptongroup.com

VERIFICATION AS TO ELIGIBILITY IS NOT A GUARANTEE OF PAYMENTS.

Call this number to verify eligibility for Plan benefits **before** the charge is Incurred.

General Limits
Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions.

Limited Benefit
There are no Benefits limited under this Plan with a dollar amount unless it is not considered an Essential Health Benefit under the terms of the Plan.

3.01 Schedule of Medical Benefits

SCHEDULE OF MEDICAL BENEFITS	
DEDUCTIBLE, PER CALENDAR YEAR	
Per Covered Person	$750
Per Family Unit	$1,500
No family Covered Person will contribute more than the individual Deductible amount.	
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR. This amount INCLUDES the plan Deductible, Copays and RX Copays	
Per Covered Person	$5,000
Per Family Unit	$10,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. Each individual never has to meet more than the individual annual Out-of-Pocket maximum annually.	
The following charges do not apply toward the Plan's Out-of-Pocket Amount and are never paid at 100%: Amounts in excess of the Maximum Allowable Charge Cost containment penalties Expenses for services not covered by the plan	
FEDERAL LIMITATION AMOUNT, PER CALENDAR YEAR for Medical and RX. The Plan has chosen to use the lesser Plan Out-of-Pocket Maximum instead of the Federal ACA limits. The current Federal ACA limits can be obtained at https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/.	
COPAYMENTS	
Physician Office Visit	$30
Specialist Office Visit	$50
Urgent Care Visit	$50
Therapy Services: Manipulative, Occupational, Physical, and Speech	$50
Emergency Room	$400
COVERED CHARGES Unless noted otherwise, the services listed below are reimbursed only after the applicable Deductible has been satisfied. The Plan will then pay a percentage as indicated until you meet the Maximum Out-of-Pocket Amount required. All references to Covered Charges means only the Maximum Allowable Charge. Charges which are not Covered Charges or are in excess of Maximum Allowable Charge are not covered and are your responsibility.	

VOLUNTARY CONSUMER SAVINGS PROGRAMS	
NOTE: Kempton Premier Provider™ benefits will only apply if the Plan is the primary Plan. If the Plan is secondary, this benefit is not available. Coordination for Kempton Premier Provider benefits will be handled by calling a Kempton Care Advocate at 866-898-7219. ***Non-inpatient services provided under the Kempton Premier Provider program will be excluded from the Preauthorization requirements.***	
Kempton Premier Providers ™ "Consumer Driven Options"	100% of Covered Charges, ***Deductible waived*** ***NOTE:*** may approve a reimbursement for reasonable travel and/or accommodation costs
Laboratory Card Program	100% of Covered Charges, ***Deductible waived***, when the laboratory designated on your ID Card is used.
Other 100% Labs (Direct Contract Labs) ➢ Clinical Pathology Laboratories, Inc. ➢ Heart of Texas Healthcare Systems (lab services only) ➢ Lavaca Medical Center (lab services only) ➢ Share Medical Center (lab services only)	100% of Covered Charges, ***Deductible waived,*** when a direct contracted lab provider is used.
Val Verde Regional Medical Center **Val Verde Regional Medical Center Rural Health Clinic** **VVRMC Specialty Group Providers**	100% of Covered Charges, ***Deductible waived***
PHYSICIAN SERVICES	
Physician Office Services • Includes: OV, lab, x-rays, and non-surgical injections	$30 Copay, then 100% of Covered Charges
Specialist Office Services • Includes: OV, lab, x-rays, and non-surgical injections	$50 Copay, then 100% of Covered Charges
Urgent Care Services • Includes: OV, lab, x-rays, and non-surgical injections	$50 Copay, then 100% of Covered Charges
Allergy Services • Testing, Serum, and Injections	OV Copay, then 100% of Covered Charges
Office Surgery	80% of Covered Charges after the Deductible
Other Physician Services • Inpatient visits • Surgery (not in the office)	80% of Covered Charges after the Deductible
Telehealth	See type of service (Office, Hospital, etc.)
HOSPITAL AND OTHER FACILITY SERVICES	
Room & Board and Ancillary Services • ICU and Observation	80% of Covered Charges after the Deductible
Emergency Room (all services) Emergency room Copay is *waived* if: • you are admitted to the Hospital	$400 Copay, then 100% of Covered Charges
Skilled Nursing Facility • Limited to 30 days per Calendar Year	80% of Covered Charges after the Deductible
Outpatient Surgery	80% of Covered Charges after the Deductible
Outpatient Procedures / Diagnostic Testing Including but not limited to: Bone Density, Colonoscopy, Mammograms, Stress Test	80% of Covered Charges after the Deductible
ADVANCED RADIOLOGY	
MRIs, CT Scans, PET Scans, or Nuclear Medicine	80% of Covered Charges after the Deductible
LAB AND XRAY	
Outpatient Lab and X-ray services	80% of Covered Charges after the Deductible
MENTAL HEALTH AND SUBSTANCE ABUSE	
Inpatient Hospital	80% of Covered Charges after the Deductible
Outpatient Hospital	80% of Covered Charges after the Deductible
Office setting	OV Copay, then 100% of Covered Charges

THERAPY SERVICES	
Cardiac Rehabilitation • Limited to 36 visits per Calendar Year. Additional visits require Medical Necessity review	80% of Covered Charges after the Deductible
Chemotherapy & Radiation Services	80% of Covered Charges after the Deductible
IV Infusion Therapy	80% of Covered Charges after the Deductible
Manipulative Therapy • Limited to 26 visits per Calendar Year. Additional visits require Medical Necessity review	$50 Copay, then 100% of Covered Charges
Occupational Therapy • Limited to 26 visits per Calendar Year. Additional visits require Medical Necessity review	$50 Copay, then 100% of Covered Charges
Physical Therapy • Limited to 26 visits per Calendar Year. Additional visits require Medical Necessity review	$50 Copay, then 100% of Covered Charges
Pulmonary Rehabilitation • Limited to 36 visits per Calendar Year. Additional visits require Medical Necessity review	80% of Covered Charges after the Deductible
Speech Therapy • Limited to 26 visits per Calendar Year. Additional visits require Medical Necessity review	$50 Copay, then 100% of Covered Charges
OTHER MEDICAL SERVICES AND PROCEDURES	
Ambulance Service, Air or Ground • Air Ambulance limited to 120% of the Medicare rate which includes three components: the Base Rate, mileage and other services.	80% of Covered Charges after the Deductible
Autism Spectrum Disorder / Developmental Delays	Covered as any other medical condition. See type of service (Office, Hospital, etc.)
Bariatric Procedures • Limited to KPP*Free* provider only	See KPP*Free* Benefits
Breast Pump Manual or Non-Manual (electric) • One per pregnancy • Non-Manual (electric) limited to $250 allowable	100% of Covered Charges, Deductible waived
Dental Services under Medical Accident, Anesthesia / Facility, Oral Surgery • Limitations apply	80% of Covered Charges after the Deductible
Diabetes Services – • Education • Testing Supplies • Insulins Pump & Supplies • Eye Exams	80% of Covered Charges after the Deductible
Dialysis Services	**THIS IS A LIMITED BENEFIT**. Covered hemodialysis and peritoneal dialysis charges, including the administration, and drug and /or supply charges, will be paid as a single charge, at the lesser of (i) 240% of rate published by Medicare as the ESRD PPS base rate for the Calendar Year, or (ii) the PPO allowable amount. 80% of Covered Charges after the Deductible
Durable Medical Equipment • Replacement equipment and supplies are covered if deemed medically necessary	80% of Covered Charges after the Deductible
Hearing Aids • Children up to age 19 – no limit • Age 20 and over – limited to $2,500 per ear per lifetime (includes replacements)	80% of Covered Charges after the Deductible
Hearing Exam and Testing	80% of Covered Charges after the Deductible
Home Health Care • Limited to 60 days per Calendar Year	80% of Covered Charges after the Deductible
Hospice Care	80% of Covered Charges after the Deductible

Implants and Medical Devices	80% of Covered Charges after the Deductible
Infertility • Not covered, however services required to treat or correct the underlying causes of infertility are covered	Covered as any other medical condition. See type of service (Office, Hospital, etc.)
Intraoperative Monitoring	80% of Covered Charges after the Deductible
Maternity • Dependent Children **ARE** covered.	80% of Covered Charges after the Deductible
Maternity – Prenatal Care	100% of Covered Charges, Deductible waived
Organ Transplant • **CONTACT THE CLAIMS ADMINISTRATOR TO UTILIZE THIS BENEFIT**	80% of Covered Charges after the Deductible
Orthotics / Prosthetics • Repair and replacement covered if medically necessary	80% of Covered Charges after the Deductible
Sleep Studies	80% of Covered Charges after the Deductible
Sterilization – Males only	80% of Covered Charges after the Deductible
TMJ Related Services	Not covered except for services rendered under the KPP*Free* program
Wig and Scalp Prosthesis • Limited to 2 per Calendar Year after chemotherapy or radiation treatment	80% of Covered Charges after the Deductible
PREVENTIVE CARE	
A full description of Preventive and Wellness Services can be found at www.healthcare.gov/coverage/preventive-care-benefits or uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations	
Routine Services outside the ACA and USPSTF recommended age range • Must be Medically Necessary	80% of Covered Charges after the Deductible
ADULT PREVENTIVE CARE	
Well Adult Exam	100% of Covered Charges, Deductible waived
Immunizations / Vaccines	100% of Covered Charges, Deductible waived
Includes**:** Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma virus, Influenza, Measles, Mumps, Rubella, Meningococcal, Pneumonia, Tetanus, Diphtheria, Pertussis, Varicella and those recommended by the Centers for Disease Control and Prevention (CDC).	
Bone Density/ Osteoporosis Screening • Women age 65 and over • Once every 24 months	100% of Covered Charges, Deductible waived
Colorectal Cancer Screening • Age 45 or older • Fecal occult blood test - limited to once every year. • sDNA-FIT (Cologuard) – limited to once every 3 years. • CT colonography and flexible sigmoidoscopy - limited to once every 5 years. • Colonoscopy - limited to once every 10 years.	100% of Covered Charges, Deductible waived
Mammogram Screening • Age 35 and over • Limit 1 per Calendar Year	100% of Covered Charges, Deductible waived
Prostate Exam / PSA • Age 40 and Over • 1 per Calendar Year	100% of Covered Charges, Deductible waived
Routine Patient Costs Associated with Approved Clinical Trials	Covered as any other medical condition. See type of service (Office, Hospital, etc.)
Smoking Cessation Counseling • Limited to 8 visits per Calendar Year	100% of Covered Charges, Deductible waived
WOMEN'S PREVENTIVE HEALTH	
Well Women Exam	100% of Covered Charges, Deductible waived

Birth Control Services • IUD or Implantable Rods – including removal • Cost and fitting of contraceptive devices • Birth control injections and related office services	100% of Covered Charges, Deductible waived
Sterilization Services - Women	100% of Covered Charges, Deductible waived
CHILDREN'S PREVENTIVE HEALTH	
Well Child Exam	100% of Covered Charges, Deductible waived
Immunizations / Vaccines	100% of Covered Charges, Deductible waived
Includes**:** Diphtheria, Tetanus, Pertussis, Haemophilus influenza type b, Hepatitis A, Hepatitis B, Human Papilloma virus, Inactivated Poliovirus, Influenza, Measles, Mumps, Rubella, Meningococcal, Rotavirus, Varicella and those recommended by the Centers for Disease Control and Prevention (CDC).	
Routine Hearing	100% of Covered Charges, Deductible waived

3.02 Preauthorization

Inpatient Services
The following services must be preauthorized or reimbursement from the Plan may be reduced:

1. **Hospitalizations;**

Non-Inpatient Services
The following services (to the extent provided by non-Kempton Premier Providers™, as outlined within Section 3.03) must be preauthorized or reimbursement from the Plan may be reduced:

1. **Outpatient procedures;**
2. **Sleep studies; and**
3. **MRI, PET, and CT scans.**

Remember that although the Plan will automatically preauthorize a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery, it is important to have your Physician call to obtain preauthorization in case there is a need to have a longer stay. Please see the Cost Management Section for details.

3.03 Consumer Driven Options; Voluntary Savings Program

As a Covered Person in the Plan you sometimes have the ability to control costs for the Plan and for yourself. This Plan has access to a select group of Providers that offer consumer driven options. These Providers are referred to as "Kempton Premier Providers™." They are listed online at www.kemptongroup.com. The Plan may authorize new Providers or eliminate Providers currently listed at any time. Therefore, you must check the website for the current list of Kempton Premier Providers™. By using Kempton Premier Providers™, you save and the Plan saves. If you are not able to see the information online, please contact the Kempton Group at 1-866-898-7219 or 1-405-608-5103 and they will provide you the information you need.

NOTE: Non-Inpatient services provided under the Kempton Premier Provider™ program will be excluded from the Preauthorization requirements as described in Sections 3.02 and 5.01. The Plan Administrator, in its sole and complete discretion, may approve a reimbursement for reasonable travel and/or accommodation costs Incurred in order to receive services at the Kempton Premier Provider™.

The Plan Administrator wants to encourage Covered Persons to be better consumers of health care.

Covered procedures/services that fall outside the Kempton Premier Provider™ will be considered under the current Plan benefits.

When you use a Kempton Premier Provider™ for a treatment or medical service that is a Covered Charge under the Plan, the Plan will pay the Covered Charges at 100%. There is no Deductible or Copayment for the covered services received at a Kempton Premier Provider™. The Plan is able to do this because these Providers generally offer transparent and direct pricing that allows everyone to know the price for the service upfront.

Each Covered Person has a free choice to use any Provider for the treatment of any medical condition. You are not required to use any Kempton Premier Provider™. If you wish to use the Kempton Premier Providers™ you will start by contacting the Kempton Group at 1-866-898-7219 or 405-608-5103. The Premier Provider Advocate will assist you in making the arrangements and ensure the procedure is one that is performed under this benefit. The Premier Provider Advocate will provide you a Temporary Identification Card or voucher.

You and your Physician are ultimately responsible for determining the appropriate course of medical treatment. Neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any Provider. It is important that you be familiar with the services offered by the Kempton Premier Providers™ and that you make an appropriate evaluation of the services offered.

This Consumer Driven Option provides payment only for services that are otherwise covered. If you use a Kempton Premier Provider™ for a service that is **not** covered under the Plan, the Plan will **not** pay for the service. This Consumer Driven Option is subject to the plan exclusions, limitations or other restrictions listed in the Plan which may apply.

Other Voluntary Savings Programs - Consumer Driven Options

Laboratory Card Program. Covered Charges include charges for laboratory services. Laboratory tests are often expensive. The Plan has contracted with a laboratory Provider to help keep the costs down. The laboratory designated by the Plan is listed on your ID Card. You are not required to use the laboratory listed on your ID Card; however, you may save the Plan and yourself some costs if you do. The Plan will pay Covered Charges for laboratory tests and test results performed at the laboratory listed on your ID Card at 100%, Deductible waived as described under *Laboratory Card Program* in the Schedule of Medical Benefits. ***You must request the service.*** You must request that the specimen given at the Physician's office be sent to the laboratory listed on your ID Card for testing. The Physician's office will call the laboratory designated on your ID Card to pick up the specimen given and the test results will be returned only to the Physician.

The use of the laboratory listed on your ID Card does ***not*** expand the Covered Charges under the Plan, only those tests that are otherwise covered under the Plan are permitted.

NOTE: Covered Charges for Outpatient laboratory tests and test results done at any laboratory other than the laboratory Provider listed on your ID Card will be paid as described in the Schedule of Medical Benefits under *Laboratory Services*.

3.04 In-Network Providers

The Plan is a plan which contains a network Provider organization.

Please refer to the back of your ID Card for your network Provider organization name and phone number.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care Providers, which are called In-Network Providers.

When a Covered Person uses an In-Network Provider, that Covered Person will not receive a balance billing statement. The Covered Person could be balance billed when an Out-of-Network Provider is used. It is the Covered Person's choice as to which Provider to use. A list of In-Network Providers in your PPO is available to you online. It is at www.kemptongroup.com. If you are not able to see the information online, please contact the Claims Administrator who will provide you with the information you need.

If a Participant receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Participant receives such item or service in reliance on that information, the Participant's Coinsurance, Copayment, Deductible, and out-of-pocket maximum will be calculated as if the Provider had been In-Network despite that information proving inaccurate.

3.05 Out-of-Network Providers

The Covered Charges will be based on the "Medicare Approved Amount" plus a percentage, for services received Out-of-Network. *Medicare generates the Medicare Approved Amounts each year.* This does not mean you have to be a Medicare covered participant. It means only that the Medicare Approved Amount will be used by the Plan to determine the Maximum Allowable Charge that the Plan will consider for the Covered Charge.

The Medicare Approved Amount is the cost of the service that the Plan will use to determine its benefits for Out-of-Network Providers. The amount will be increased as follows:

1. Physicians and other Providers will be limited to 130% of their current Medicare Approved Amount.
2. Facilities and Hospitals will be limited to 160% of their current Medicare Approved Amount.
3. Laboratory Services will be limited to 100% of their current Medicare Approved Amount.
4. Anesthesia performed by an anesthesiologist will be limited to 250% and CRNA will be limited to 200% of their current Medicare Approved Amount.
5. Emergency Room services will be limited to 200% of their current Medicare Approved Amount.
6. Air Ambulance will be limited to 120% of their current Medicare Approved Amount.
7. Ground Ambulance will be limited to 200% of their current Medicare Approved Amount.
8. Dialysis will be limited to 240% of their current Medicare Approved Amount.

In some cases, if the service does not have a Medicare Approved Amount, the amount billed will be reduced to a Usual and Customary amount for payment by the Plan.

The Deductible and Out-of-Pocket amounts are applied to the adjusted Medicare Approved Amount.

Many Providers will accept the payment as payment-in-full from the Plan; *however, some may not*. If the Provider does not accept the payment as payment-in-full from the Plan, the Provider may bill you for the amount it determines it is still owed. ***This is called "balance billing".*** Generally, if you intend to use an Out-of-Network Provider, you may be able to negotiate the balance due from you. The amount a Provider balance bills you is *your* responsibility and is not payable by the Plan.

3.08 Copayments/Coinsurance and Deductibles Payable by Covered Persons

The Plan has certain costs that the Covered Person must pay before it begins to pay benefits. There are two types of amounts: Copayments/Coinsurance and Deductibles.

1. A **Copayment/Coinsurance** is the amount of money that the Covered Person must pay each time a particular service is used. There are Copayments/Coinsurance on some services, but not all services. Copayments do not count towards the required Deductible, but Coinsurance does; and
2. A **Deductible** is the amount of money for covered services that a Covered Person must pay for him or herself before the Plan will begin its payments. Each Calendar Year, a new Calendar Year Deductible amount is required.

3.06 Maximum Out-of-Pocket Amount Payable by Covered Persons

The maximum out-of-pocket amount is the Maximum Allowable Charge that the Covered Person pays for him/herself, or if the Covered Person selected coverage for a Family Unit, the Maximum Allowable Charge that the Covered Person pays for the Family Unit each Calendar Year. All charges that apply toward the Covered Person's maximum out-of-pocket will be applied toward the Family Unit maximum out-of-pocket. When the Covered Person satisfies the Covered Person's maximum out-of-pocket, the Plan will generally pay a rate of 100% for the remainder of the Calendar Year for that Covered Person. When the Family Unit maximum out-of-pocket is satisfied the Plan will generally pay a rate of 100% for the remainder of the Calendar Year for all members of the Family Unit. Note that there are some benefits for which the reimbursement rate is reduced.

3.07 ACA Limitation on Total Paid by Covered Persons

The Affordable Care Act (ACA) requires that the Plan limit the maximum exposure that a Covered Person, or the Covered Persons making up a Family Unit, have for amounts expended for Essential Health Benefits. The Plan intends to comply with the Federal limitation set by ACA. The amount listed in the Plan for the out-of-pocket amount (above)

is NOT the maximum allowed by Federal law. The Federal out-of-pocket maximum amount allowed under ACA will be calculated under this Section.

The Plan will apply the following conditions to determine if any Covered Person exceeds the Federal out-of-pocket maximum amount:

1. Each Benefit Year the Federal out-of-pocket maximum amount will be updated according to the amount set forth by the current Affordable Care Act (ACA) regulations.
2. No Covered Person shall be required to meet more than the individual limit.
3. Only amounts expended for In-Network services are considered. Any amounts that a Covered Person pays related to Out-of-Network services are NOT considered.
4. The Federal out-of-pocket maximum amount is determined by adding the amounts paid by the Covered Person or the Family Unit, as applicable, for In-Network services, including:
    a. The Deductibles;
    b. The normal Plan out-of-pocket amounts; and
    c. Copays required by the Plan including any Copayment or out-of-pocket requirement for Prescription Drugs.

The following **expenses paid by the Covered Person will not be included to determine the maximum**:

1. Any amounts paid for medical services that are not covered by the Plan.
2. Any amounts paid for medical services that are in excess of the coverage provided by the Plan, including amounts that exceed Usual and Customary charges paid by the Plan, or disallowed amounts which are penalties for failure to comply with the terms of the Plan.
3. Any amounts for any service that is received Out-of-Network.
4. Any amounts in excess of the limit for services as set forth in the Plan.
5. Any amount for services that are not Essential Health Benefits.

The Plan is designed to accumulate the amounts that apply to the Federal out-of-pocket maximum amount and will stop requiring any further out-of-pocket amounts from you when the Federal limit is reached. Remember that the amount that is applied depends on whether you have single coverage or coverage for a Family Unit.

3.08 Balance Billing

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

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

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

3.09 Claims Audit

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

The analysis will be employed to identify charges billed in error and/or charges that exceed the Maximum Allowable Charge and/or are not:

1. Medically Necessary; and/or
2. Usual and Customary for services rendered by an In-Network Provider; and/or
3. Medicare Approved Amount for Out-of-Network Providers; and

May include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the converse, the Plan Administrator has the discretionary authority to reduce any charge to a Maximum Allowable Charge, in accord with the terms of this Plan Document.

3.10 No Surprises Act – Emergency Services and Surprise Bills

For Non-Network claims subject to the No Surprises Act ("NSA"), Participant cost-sharing will be the same amount as would be applied if the claim was provided by a Network Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward In-Network Deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a Participating Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and
- Covered Non-Network air ambulance services.

3.11 Continuity of Care

In the event a Participant is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan shall notify the Participant in a timely manner, but in no event later than 30 calendar days after termination that the Provider's contractual relationship with the Plan has terminated, and that the Participant has rights to elect continued transitional care from the Provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1. is undergoing a course of treatment for a serious and complex condition from a specific Provider,
2. is undergoing a course of institutional or Inpatient care from a specific Provider,
3. is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,
4. is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
5. is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, Plan benefits will be processed as if the termination had not occurred, however, the Provider may be free to pursue the Participant for any amounts above the Plan's benefit amount.

3.12 Transition of Care

If a Participant is under the care of a Non-Network Provider at the time of joining the Plan, there are a limited number of medical conditions that may qualify for transition of care. If transitional care is appropriate, specific treatment by a Non-Network Provider may be covered at the Network level of benefits for a limited period of time. The Third Party Administrator will review and approve or deny such requests.

ARTICLE IV
MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are Incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

4.01 Deductible

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the Deductible shown in the Schedule of Medical Benefits.

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

4.02 Benefit Payment

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the Deductible. Payment will be made at the percentage shown in the Schedule of Medical Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

4.03 Out-of-Pocket Limit

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Medical Benefits is reached. Then, Covered Charges Incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year. All charges that apply toward the Covered Person's maximum out-of-pocket will be applied toward the Family Unit maximum out-of-pocket. When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year. No Covered Person will contribute more than the Covered Person out-of-pocket maximum to the Family Unit maximum out-of-pocket maximum.

4.04 Maximum Benefit Amount

The Maximum Benefit Amount is shown in the Schedule of Medical Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges Incurred by a Covered Person. All benefits are subject to the Maximum Allowable Charge.

4.05 Covered Medical Benefits

The Schedule of Medical Benefits shows Deductibles and Copayments, as well as any Plan maximums and Plan Coinsurance payment percentages. Services must be Medically Necessary. The Plan payment will not exceed the Maximum Allowable Charge as defined in the Definitions section. Unless otherwise noted for a particular service or supply, the service or supply must be required as a result of symptoms of Illness. All Providers, including facilities, must be licensed in accordance with the laws of the appropriate legally authorized agency, and acting within the scope of such license. Expenses are covered only if Incurred while the Covered Person is covered for these medical benefits.

1. **Allergy Services**
   Charges related to the treatment of allergies.

2. **Ambulance, Air or Ground**
   Air or ground ambulance when used to transport a Covered Person:

   a. From place of Illness or Injury to the nearest Hospital or Skilled Nursing Facility where appropriate treatment can be provided
      i. Air Ambulance subject to Medical Necessity and limited to 120% of the Medicare allowable amount which consists of three components: a base rate, mileage, and other services; or
   b. From one Hospital to another, when Medically Necessary.

3. **Ambulatory Surgical Center**
   Services of an Ambulatory Surgical Center for Medically Necessary care provided.

4. **Anesthesia**
   Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff.

5. **Autism Therapy**
   Autism Spectrum Disorders (ASD) treatment, when Medical Necessity is met. (ASD includes Autistic Disorder, Asperger's Syndrome, Childhood Disintegrative Disorder, Rett Syndrome, and Pervasive Developmental Disorders.)

   ASD treatment may include any of the following services: diagnosis and assessment; psychological, psychiatric, and pharmaceutical (medication management) care; speech therapy, occupational therapy, and physical therapy; or Applied Behavioral Analysis (ABA) therapy.

   Treatment is prescribed and provided by a licensed health care professional practicing within the scope of his or her license (if ABA therapy, preferably a Board Certified Behavior Analyst, or BCBA).

   Treatment is subject to all other Plan provisions as applicable (such as Prescription benefit coverage, behavioral/mental health coverage, and/or coverage of therapy services). Coverage does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Experimental, Investigational, or Unproven treatment, custodial care, nutritional or dietary supplements, or educational services that should be provided through a school district).

   Benefits will be paid as described in the Schedule of Benefits.

6. **Birthing Center**
   Services of a Birthing Center for Medically Necessary care provided within the scope of its license.

7. **Breast Pump**
   Manual breast pump as required by the Affordable Care Act (ACA) and non-manual breast pumps covered as noted in the Schedule of Medical Benefits.

8. **Cardiac Rehabilitation**
   This Plan covers, as deemed Medically Necessary, provided services rendered (1) under the direct supervision of a Physician; (2) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (3) initiated within 12 weeks after other treatment for the medical condition ends; and (4) in a Medical Care Facility as defined by this Plan.

9. **Cataracts**
   Charges for cataract surgery and initial set of lenses included with the surgery. Replacement lenses are covered if determined to be Medically Necessary.

10. **Chemotherapy**
    Charges for chemotherapy/radiation. The materials and services of technicians are included.

11. **Contraceptives**
    The charges for all Food and Drug Administration (FDA) approved contraceptive Drugs or methods, in accordance with Health Resources and Services Administration (HRSA) guidelines.

12. **Coronavirus: 2019 Novel Coronavirus (COVID-19)**
    Covered Charges associated with testing for COVID-19 include the following:

    a. *Diagnostic Tests.* The following items are covered at 100%, deductible waived, as provided in the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and notwithstanding any otherwise-applicable Medical Necessity or

Experimental and/or Investigational requirements, and do not require Pre-Certification. These items are paid at the negotiated rate, if one exists. If no negotiated rate exists, the Plan will pay the cash price publicly posted on the Provider's website, or such other amount as may be negotiated by the Provider and Plan.

i. In vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 (including all costs relating to the administration of such in vitro diagnostic products) which satisfy **one** of the following conditions:
   - that are approved, cleared, or authorized by the FDA;
   - for which the developer has requested or intends to request emergency use authorization under Section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;
   - that are developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or
   - that are deemed appropriate by the Secretary of Health and Human Services.

ii. Items and services furnished during an office visit (including both in-person and telehealth), urgent care visit, or emergency room visit which results in an order for or administration of an in vitro diagnostic product described above. Such items and services must relate to the furnishing of such diagnostic product or evaluation of the individual for purposes of determining the need for such product.

b. *Qualifying Coronavirus Preventive Services.* The following items are covered at 100%, deductible waived, and do not require Pre-Certification.

i. An item, service, or immunization that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; and

ii. An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

The above benefits are specific to Diagnosis of COVID-19. Participants who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the Plan, in accordance with the Plan's guidelines.

This benefit will terminate upon the expiration of the public health emergency relating to COVID-19 and declared pursuant to 42 U.S.C. § 247d.

13. **Custom-Made Orthotics**
Custom-made orthotics when prescribed by a doctor and required for all normal, daily activities.

Repair and replacement of custom-made orthotics are covered if determined to be Medically Necessary.

14. **Dental**
The following expenses will be covered under the Plan:

a. **Accident.** Dental services or supplies needed to correct damage caused by an Accident; and the Accident occurred while medical expense benefits for the Covered Person are in effect.

b. **Hospital Expenses.** Outpatient Hospital charges, or if necessary, Hospital room charges and Hospital miscellaneous expenses, will be covered when dental services are rendered only if the Hospital services are required because there is no other alternative available under the circumstances. This benefit is intended to be very limited and shall be provided only when the Plan Administrator determines the Covered Person had a special need to receive such services at a Hospital.

c. **Tumors and Cysts.** The treatment of tumors and the treatment of cysts which do not result from infection of the teeth or gums are covered under this Plan. This benefit is limited only to those

services requiring treatment of tumors or cysts in the mouth area which are not caused by or created by any infection of the teeth or gums.

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

15. **Diabetes and Diabetes Self-Management Education Programs**
Services required for the treatment of diabetes and diabetes self-management education programs.

16. **Diagnostic Tests; Examinations**
Charges for x-rays, microscopic tests, laboratory tests and other diagnostic tests and procedures.

17. **Dialysis Services**
This is a limited benefit. Benefits provided under this Plan for treatment received in connection with dialysis, to include, Outpatient dialysis, Inpatient dialysis (hemodialysis) or home dialysis (peritoneal dialysis) are subject to the following provisions:

Covered hemodialysis and peritoneal dialysis charges, including the administration, the Drugs and/or supply charges will be paid as a single charge and not in components. The maximum reimbursable amount will be the lesser of (i) 240% of the rate published by Medicare as the "ESRD PPS" base rate for the Calendar Year or (ii) the PPO allowable amount.

18. **Durable Medical Equipment**
Coverage includes repair or replacement of covered equipment only when repair or replacement is required as a result of normal usage. Coverage for equipment rental will not exceed the equipment's purchase price.

Supplies and replacement parts are covered if determined to be Medically Necessary.

19. **Emergency Services**
Coverage will be provided for Emergency Services if the symptoms you present and records by the attending Physician indicate that an Emergency Medical Condition exists; or for Emergency Services necessary to provide you with a medical examination and stabilizing treatment, regardless of whether prior authorization was obtained to provide those services.

20. **Enteral Nutrition**
Enteral Nutrition means medical foods that are specially formulated for enteral feedings or oral consumption. Coverage includes medically approved formulas prescribed by a Physician for the treatment of Phenylketonuria (PKU) and other Medically Necessary conditions.

The Plan covers enteral nutrition and supplies required for enteral feedings or when *all* of the following conditions are met:

a. It is necessary to sustain life or health;
b. It is used in the treatment of, or in association with a demonstrable Disease, condition or disorder;
c. It requires ongoing evaluation and management by a Physician; and
d. It is the primary source of nutrition or a significant percentage of the daily caloric intake.

Coverage does not include:

a. Regular grocery products that meet the nutritional needs of the patient (e.g., over-the-counter infant formulas such as Similac, Nutramigen and Enfamil); or
b. Medical food products:
    i. prescribed without a diagnosis requiring such foods;
    ii. used for convenience purposes;

iii. that have no proven therapeutic benefit without an underlying Disease, condition or disorder;
iv. used as substitute for acceptable standard dietary intervention; or
v. used exclusively for nutritional supplementation.

21. **Foot Care** (Podiatry)
Foot care (podiatry) that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

a. Treatment of any condition resulting from weak, strained, flat, unstable, or unbalanced feet when surgery is performed.
b. Treatment of corns, calluses, and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
c. Physician office visit for diagnosis of bunions. The Plan also covers treatment of bunions when an open cutting operation or arthroscopy is performed.

Routine services, including routine care for bunions, corns, calluses, toenails, flat feet, fallen arches, and chronic foot strain are excluded.

22. **Genetic Testing**
Must be reviewed for Medical Necessity and meet the following requirements:

a. The test must not be considered Experimental, Investigational, or unproven.
b. The test must be performed by a CLIA-certified laboratory.
c. The test result must directly impact or influence the treatment of the Covered Person.
d. In some cases, testing may be accompanied with pre-test and post-test counseling.

Genetic testing must also meet at least one of the following:

a. The patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes).
b. Conventional diagnostic procedures are inconclusive.
c. The patient has risk factors or a particular family history that indicates a genetic cause. (up to the 2nd degree of relative)
d. The patient meets defined criteria that place him or her at high genetic risk for the condition.
e. Prenatal testing is covered when the pregnancy is categorized as high-risk, including cases where the mother is 35 years of age or older, or if the mother or father has a family history that establishes him/her as at-risk for having a hereditary genetic disorder.

Generally, genetic testing is not covered for:

a. Population screening without a personal or family history, with the exception of preconception or prenatal carrier screening for certain conditions, such as cystic fibrosis, Tay-Sachs disease, sickle cell disease, and other hemoglobinopathies.
b. Informational purposes alone (e.g., testing of minors for adult-onset conditions and self-referrals or home testing).
c. Experimental, Investigational, or unproven purposes.

23. **Hearing Aids**
Charges for hearing aids, which includes examinations for the prescription, fitting, and/or repair of hearing aids. Benefits will be paid as described in the Schedule of Benefits.

24. **Home Health Care Services and Supplies**
Home Health Care Services and Supplies as covered in the Schedule of Medical Benefits.

Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Illness or Injury when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care, and treatment must be certified by the attending Physician and be contained in a home health care plan.

Home Health Care Services and Supplies are provided only if Case Management has determined that the home is a medically appropriate setting. If the Covered Person is a minor or an adult who is dependent upon others for non-skilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Care Services will be provided for the person only during times when there is not a family member or care giver present in the home to meet your non-skilled care and/or custodial service needs.

Home Health Care Services and Supplies are those skilled health care services that can be provided during visits by other health care professionals as defined here. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by other health care professionals. Necessary consumable medical supplies and home infusion therapy administered or used by other health care professionals in providing Home Health Care Services and Supplies are covered.

Home Health Care Services and Supplies do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is another health care professional.

Nursing services provided in the home are subject to the Home Health Care Services and Supplies benefit terms, conditions and benefit limitations. Physical therapy provided in the home is subject to the Home Health Care Services and Supplies benefit limitation described the in Schedule of Medical Benefits. Outpatient occupational, speech and hearing therapy provided in the home is subject to the Home Health Care Services and Supplies benefit limitations described within the Schedule of Medical Benefits.

As used in this provision, "other health care professional" means an individual other than a doctor who is licensed or otherwise authorized under the applicable State law to deliver medical services and supplies. Other health professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other health professionals do not include Providers such as certified first assistants, certified operating room technicians, certified surgical assistants/technicians, licensed certified surgical assistants/technicians, licensed surgical assistants, orthopedic Physician assistants and surgical first assistants.

25. **Hospice Care**
    The Plan covers hospice care if prescribed by a doctor and the Covered Person's life expectancy is six months or less.

26. **Hospital Care**
    The medical services and supplies furnished by a Hospital, Ambulatory Surgical Center, or a Birthing Center. Covered Charges for room and board are payable as shown in the Schedule of Medical Benefits. Charges for an Intensive Care Unit stay are payable as described in the Schedule of Medical Benefits. ***NOTE:*** *The Plan will not pay for any charges for nursing services regardless of name used by a Hospital.*

27. **Implantable Hearing Devices.** For Medically Necessary services or supplies in connection with implantable hearing devices, including, but not limited to, cochlear implants and exams for their fitting, when services are provided through the Kempton Premier Provider™ program.

28. **Implants and Medical Devices**
    Covered Charges for services related to implants and medical devices will be paid as described in the Schedule of Medical Benefits.

29. **Infertility Testing**
    The Plan covers diagnostic testing for the purpose of diagnosing the underlying cause of infertility.

30. **Intraoperative Monitoring**
    Covered Charges for services related to intraoperative monitoring will be paid as described in the Schedule of Medical Benefits.

31. **Laboratory Card Program**
    Covered Charges include charges for laboratory services. Laboratory tests are often expensive. The Plan has contracted with a laboratory Provider to help keep the costs down. The laboratory designated by the Plan is listed on your ID Card. You are not required to use the laboratory listed on your ID Card; however, you may save the Plan and yourself some costs if you do. The Plan will pay Covered Charges for laboratory tests and test results performed at the laboratory listed on your ID Card at 100%, Deductible waived as described under *Laboratory Card Program* in the Schedule of Medical Benefits. ***You must request the service.*** You must request that the specimen given at the Physician's office be sent to the laboratory listed on your ID Card for testing. The Physician's office will call the laboratory designated on your ID Card to pick up the specimen given and the test results will be returned only to the Physician.

    The use of the laboratory listed on your ID Card does ***not*** expand the Covered Charges under the Plan, only those tests that are otherwise covered under the Plan are permitted.

    NOTE: Covered Charges for Outpatient laboratory tests and test results done at any laboratory other than the laboratory Provider listed on your ID Card will be paid as described in the Schedule of Medical Benefits under *Laboratory Services*.

32. **Laboratory Services**
    Covered Charges are paid subject to the limitations noted in the Schedule of Medical Benefits.

33. **Manipulative Therapy**
    Covered Charges are paid subject to the limitations noted in the Schedule of Medical Benefits.

34. **Mastectomy and Reconstructive Surgery**
    The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a mastectomy. The new Federal law requires group health plans that provide mastectomy coverage to also cover breast reconstruction surgery and prostheses following mastectomy.

    As required by law, you are being provided this notice to inform you about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary mastectomy will also receive coverage for:

    a. Reconstruction of the breast on which the mastectomy has been performed;
    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    c. Prostheses and physical complications from all stages of mastectomy, including lymphedemas.
    d. Prostheses are covered, subject to the limitations noted in the Schedule of Benefits.

    This coverage will be subject to the same annual Deductible and Coinsurance provisions that currently apply to mastectomy coverage and will be provided in consultation with you and your attending Physician.

35. **Maternity/Pregnancy**
    For eligible Covered Persons, coverage may be available for expenses related to certain complications of Pregnancy. Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in

excess of 48 hours (or 96 hours). In no event will an "attending provider" include a plan, hospital, managed care organization, or other issuer.

Benefits are payable in the same manner as for medical or surgical care of an Illness, shown in the Schedule of Medical Benefits and this section, and subject to the same maximums.

Benefits for Maternity/Pregnancy expenses are paid the same as any other Sickness. *NOTE: Preventive care charges for Pregnancy are covered under the Preventive Care benefit in the Medical Benefits section.*

36. **Medical Foods**
Medical foods are considered a covered charge if intravenous therapy (IV) or tube feedings are Medically Necessary. Medical foods taken orally are not covered under the Plan, except for PKU formula when Medically Necessary.

37. **Mental Disorders and Substance Abuse**
Benefits are available for Inpatient or Outpatient care for mental health and substance use disorder conditions, including individual and group psychotherapy, psychiatric tests, and expenses related to the diagnosis when rendered by a covered Provider.

Benefits are available for Residential Treatment Facility, Partial Hospitalization, and Intensive Outpatient Services.

38. **Midwife Services**
Benefits for midwife services performed by a certified nurse midwife (CNM) who is licensed as such and acting within the scope of his/her license. This Plan will not provide benefits for lay midwives or other individuals who become midwives by virtue of their experience in performing deliveries.

39. **Newborn Care**
Hospital and Physician nursery care for newborns who are eligible Dependents and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn Child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth. The benefit is limited to the Maximum Allowable Charge for nursery care for the newborn Child while Hospital confined as a result of the Child's birth. Benefits will be provided under the mother's coverage for the first 31 days.

    a. Routine Hospital care for a newborn during the Child's initial Hospital confinement at birth; and
    b. The following Physician services for well-baby care during the newborn's initial Hospital confinement at birth:
        i. Newborn examination; and
        ii. Circumcision.

NOTE: The Plan will cover Hospital and Physician nursery care for an ill newborn as any other medical condition, provided the newborn is properly enrolled in the Plan. These benefits are provided under the Child's coverage.

40. **Nursing Services**

41. **Obesity**
The Plan will pay for charges for one bariatric surgical procedure for the care and treatment of Morbid Obesity, when services are provided through the Kempton Premier Provider™ program. The benefit is limited to only one treatment during the Covered Person's Lifetime and is subject to the limitation in the Schedule of Medical Benefits. Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age, and mobility as the Covered Person. The Plan requires a 12-month documented weight-loss and exercise program in combination with the additional required medical criteria guidelines before the bariatric surgical procedure is approved. "Bariatric surgical procedure" includes, but is

not limited to, gastric bypass, intestinal bypass, and gastric surgery. No other benefit is provided under the Plan for the treatment of obesity or any other weight related condition.

42. **Occupational Therapy**
The Plan covers prescribed occupational therapy rehabilitation that is:

    a. performed by an appropriate health care Provider;
    b. part of a therapy program designed to improve lost or impaired function or reduce pain resulting from Illness, Injury, congenital defect or surgery;
    c. expected to result in significant improvement over a clearly defined period of time; and
    d. the program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.

43. **Office Visits and Office Services**
The Plan covers doctor office visits, lab, x-rays, non-surgical injections, allergy testing/treatment, allergy injections, and serum provided during the visit. The following are considered separate from the office visit:

    a. Surgery performed in the office; and
    b. Advanced radiology performed in the office, such as MRI, MRA, PET, CT-Scan.

44. **Organ Transplant**
The Plan provides benefits for human organ and tissue transplants if the transplant is preauthorized, and the services are rendered at an approved facility. BEFORE YOU ARRANGE FOR AN ORGAN TRANSPLANT, CONTACT THE CLAIMS ADMINISTRATOR. ALL ORGAN OR TISSUE TRANSPLANTS WILL BE COORDINATED WITH CASE MANAGEMENT. Transplants which are not preauthorized through the case management program are not covered under the Plan.

    Covered Charges are determined in the same manner as for any other Sickness.

    Transplant benefits are subject to the general exclusions, restrictions and limitations. *You must be a Covered Person to receive benefits as a donor or recipient.* Charges otherwise covered under the Plan that are Incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

    a. The transplant must be performed to replace an organ or tissue;
    b. Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. This Plan will NOT pay any benefits for the donor until the other coverage has determined the amount it shall pay. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:
        i. Evaluating the organ or tissue; and
        ii. Removing the organ or tissue from the donor;
    c. The Plan will **not** pay for the:
        i. Cost of procuring an organ or tissue from an Institution or individual. Such costs include but are not limited to: acquisition, preservation, storage and transportation costs related to the donated organ or tissue from a living donor or a cadaver;
        ii. Cost related to a donor search nor the costs related to testing or typing the organ to determine if a donation is compatible for the recipient;
        iii. Costs for removing an organ from a living donor or a cadaver NOR costs to retrieve organs or tissue from a Covered Person who has been declared clinically dead but has been maintained on life support systems to preserve the organ or tissue;
        iv. Costs related to maintaining or transporting the organ or tissue after it has been removed; and
        v. Costs to the donor if the donor sells the organ or tissue.

Notwithstanding anything to the contrary, the Plan will pay the cost for travel and accommodations only if the transplant has been preauthorized at a designated facility that has agreed to a bundled fee that includes such travel and accommodations.

Any Covered Person in need of an organ transplant may contact the Claims Administrator to initiate the preauthorization process resulting in a referral to a Center of Excellence. The Claims Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all transplant admissions taking place at a Center of Excellence.

If a Covered Person chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence.

Additional information about this option can be obtained by contacting Customer Service.

Covered Persons must contact the Claims Administrator in advance of any procedure to ensure availability of benefits.

45. **Orthotics**
The initial purchase and fitting of orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. The Plan does not pay for the repair or replacement of any orthotic appliances, unless determined to be Medically Necessary. Foot orthotics are not covered.

46. **Physical Therapy**
Physical therapy by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

Covered Charges are paid subject to the limitations noted in the Schedule of Medical Benefits.

47. **Preventive Care**
Charges for Preventive Care services.

Benefits mandated through the ACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC). Benefits include gender-specific Preventive Care services, regardless of the sex the Covered Person was assigned at birth, his or her gender identity, or his or her recorded gender.

See the following websites for more details:
https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;
https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;
https://www.hrsa.gov/womensguidelines/.

NOTE: The Preventive Care services identified through this link are recommended services, not mandated services. It is up to the Provider of care to determine which services to provide.

Preventive and Wellness Services for Adults and Children - In compliance with section 2713 of the Affordable Care Act (ACA), benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDCP) with respect to the individual involved.

With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

Women's Preventive Services - With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) not otherwise addressed by the recommendations of the United States Preventive Service Task Force (USPSTF), which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

a. Well-woman visits;
b. Gestational diabetes screening;
c. Human papillomavirus (HPV) deoxyribonucleic acid (DNA) testing;
d. Sexually transmitted infection counseling;
e. Human Immunodeficiency Virus (HIV) screening and counseling;
f. Food and Drug Administration (FDA)-approved contraception methods and contraceptive counseling;
g. Breastfeeding support, supplies and counseling (includes one manual breast pump per childbirth, covered as noted in the Schedule of Medical Benefits); and
h. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at: http://www.hrsa.gov/womensguidelines/ or at the websites listed above.

NOTE: The Preventive Care services identified through this link are recommended services, not mandated services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered. Preventive Care services will be covered at 100% for Out-of-Network Providers if there is no In-Network Provider who can provide a required preventive service.

For preventive services received outside the recommended ACA age limits or other Plan age limits are subject to the benefits listed in the Schedule of Benefits. These specific preventative services are subject to all applicable plan provisions, including limitations and exclusions.

48. **Prosthetics**
Prosthetic devices (other than dental) and orthotic devices (other than orthopedic shoes and other supportive devices for the feet) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. However, Covered Charges do **not** include the replacement cost or the maintenance cost for such braces, appliances, artificial limbs or other devices, unless determined to be Medically Necessary.

49. **Radiation Therapy**
Charges for radiation therapy and treatment.

50. **Reconstructive Surgery**
The Plan covers charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit, provided that:

a. the surgery or therapy restores or improves function;
b. reconstruction is required as a result of Medically Necessary;
c. it is non-cosmetic surgery; or

d. the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part.

Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the Case Management review.

51. **Respiratory Therapy**
Respiratory therapy services, when rendered in accordance with a Physician's written treatment plan.

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

The clinical trial is approved by:

a. The Centers for Disease Control and Prevention (CDCP) of the U.S. Department of Health and Human Services;
b. The National Institute of Health;
c. The U.S. Food and Drug Administration;
d. The U.S. Department of Defense;
e. The U.S. Department of Veterans Affairs;
f. An institutional review board of an Institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and
g. The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Maximum Allowable Charge, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

53. **Sex Assignment/Reassignment.** The Plan covers the following sex reassignment services when ordered by a Provider or Physician.

a. Psychotherapy.
b. Pre- and-post-surgical hormone therapy.
c. Sex assignment/reassignment surgery(ies). Surgery must be performed by a qualified Provider. These services require preauthorization.

54. **Skilled Nursing Facility**
Charges made by a Skilled Nursing Facility or a convalescent care facility, up to the limits set forth in the Summary of Benefits, in connection with convalescence from an Illness or Injury (excluding drug addiction, chronic brain syndrome, alcoholism, senility, intellectual disability or other Mental or Nervous Disorders) for which the Participant is confined.

55. **Sleep Disorders/Sleep Studies**
Covered Charges are paid subject to the limitations noted in the Schedule of Medical Benefits.

56. **Smoking Cessation Counseling**
Smoking cessation counseling as required by the Affordable Care Act (ACA).

57. **Speech Therapy**
The Plan covers prescribed speech therapy rehabilitation that:

a. is performed by an appropriate health care Provider;
b. is part of a therapy program designed to improve lost or impaired function or reduce pain resulting from Illness, Injury, congenital defect or surgery;
c. is expected to result in significant improvement over a clearly defined period of time; and

d. is part of a therapy program that is individualized, and there is documentation outlining quantifiable, attainable treatment goals.

58. **Sterilization**
All Food and Drug Administration (FDA) approved charges related to sterilization procedures for males and females, to the extent required by the Affordable Care Act (ACA).

59. **Surgical Dressings**
Surgical dressings used in connection with splints, casts and other devices for the reduction of fractures and dislocations.

60. **Telehealth**
Benefits are provided for the use of interactive audio, video, or other electronic media for the purpose of consultation, diagnosis, or treatment of the patient. Benefits for telehealth services shall be provided by a health care provider to deliver health care services within the scope of the provider's practice at a site other than the site where the patient is located and shall be subject to the applicable Deductibles, Copayments or out-of-pocket requirements of the Plan (see Schedule of Medical Benefits for specific types of service, e.g., office service, mental health, etc.). Telehealth services do not include unidirectional telephone calls (e.g., automated voice response systems), electronic mail messages, or facsimile transmission between a provider and patient. Telehealth services under this section are separate and apart from those offered under any Telemedicine Program.

61. **Telemedicine Program**
This Plan has a benefit allowing Covered Persons to receive telephone or web-based video consultations through a network of physicians that is designed to facilitate cross-coverage medical consultations when a patient's primary care physician is unavailable.

Once enrolled, a Covered Person may call the telephone number listed on the Covered Person's enrollment packet and request a consultation with a physician. Typically, a licensed physician will respond within one hour. If a Covered Person requests a video consultation, it will be scheduled and an appointment reminder will be sent prior to the appointed time. When appropriate, the physician will provide a diagnosis, recommend therapy, and if necessary, write a prescription. The prescription will be called into the pharmacy of the Covered Person's choice.

This Telemedicine Program may not be used for Drug Enforcement Agency controlled Prescriptions, charges for telephone or online consultations with physicians and/or providers who are not contracted with this Plan's Telemedicine Program, or web-based video consultations provided in states that do not allow telemedicine programs.

62. **Treatment of Injury to Sound/Natural Teeth Within Six Months After the Accident**
Treatment of Injury to sound/natural teeth within six months after the Accident. "Sound/natural" means teeth that are free from defect or Disease and are not artificial. A chewing injury is not considered to be an Injury.

63. **Treatment of TMJ and Related Disorders**
The Plan covers treatment of Temporomandibular Joint disorders and craniofacial muscle disorders when services are provided through the Kempton Premier Provider™ program.

64. **Urgent Care**
An office or a clinic whose purpose is to diagnose and treat Illness or Injury for unscheduled, ambulatory patients seeking immediate medical attention. Covered Charges are paid subject to the limits noted in the Schedule of Medical Benefits.

ARTICLE V
COST MANAGEMENT SERVICES

Cost Management Services Phone Number
Please refer to the Covered Person's ID Card for the cost management services company and phone number.

The patient or family member must call this number to receive authorization of certain cost management services. This call must be made at least 48 hours in advance of services being rendered or within 48 hours after an Emergency.

5.01 Utilization Review
Utilization review is a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

1. Preauthorization of the Medical Necessity for the following non-Emergency Services before medical and/or surgical services are provided (excluding non-inpatient services provided under the Kempton Premier Provider™ program as set forth in Section 3.02):
    a. **Hospitalizations;**
    b. **Outpatient procedures;**
    c. **Sleep studies; and**
    d. **MRI, PET, and CT scans.**

    All Outpatient procedures are required to be preauthorized. The preauthorization or utilization review administrator will authorize services based on the specific requirement of the Plan.

2. Retrospective review of the Medical Necessity of the listed services provided within the timely filing parameters for the claim;
3. Concurrent review, based on the admitting diagnosis of the listed services requested by the attending Physician; and
4. Authorization of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care Provider.

If a particular course of treatment or medical service is not authorized, it means that the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

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

Here's how the program works.

Preauthorization. Before a Covered Person enters a Medical Care Facility on a non-Emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-Emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. The Covered Person should contact the utilization review administrator at the telephone number located on their ID Card **at least 48 hours before** services are schedule to be rendered with the following information:

1. The name of the patient and relationship to the covered Employee;
2. The name, member ID number and address of the covered Employee;

3. The name of the Employer;
4. The name and telephone number of the attending Physician;
5. The name of the Medical Care Facility, proposed date of admission, and proposed length of stay;
6. The diagnosis and/or type of surgery; and
7. The proposed rendering of listed medical services.

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

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

Non-inpatient services provided under the Kempton Premier Provider™ program, as set forth in Section 3.02, will be excluded from the Preauthorization requirements described herein.

If the Covered Person does not receive authorization as explained in this section, the claim will be denied. If you request a retrospective review of the claim and the services are allowed after such review, the reimbursement rate will be subject to the benefits as shown in the Schedule of Medical Benefits.

NOTE: *If a Covered Person's admission or service is determined to not be Medically Necessary, he or she may pursue an appeal by following the provisions described in the Claims Procedures; Payment of Claims section of this document. The Covered Person and Provider will be informed of any denial or non-certification in writing.*

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

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been preauthorized, the attending Physician must request and receive approval for the additional services or days.

5.02 Second and/or Third Opinion Program

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an Emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other Sickness.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Hernia surgery	Spinal surgery

Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

6.03 Case Management

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

Case Management is a program whereby a case manager monitors these patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

1. Personal support to the patient;
2. Contacting the family to offer assistance and support;
3. Monitoring Hospital or Skilled Nursing Facility;
4. Determining alternative care options; and/or
5. Assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

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

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

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.

ARTICLE VI
PRESCRIPTION DRUG BENEFITS

6.01 General Prescription Benefit Information

This summary provides a general description of your Prescription Drug benefits. It does not list all benefits. This Plan contains limitations and restrictions that could reduce the benefits payable under the Plan.

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Please refer to the back of your ID Card for the name and phone number of your Pharmacy Benefit Manager (PBM), who is the administrator of the Prescription Drug benefit.

Covered Charges are subject to the Covered Person's cost share described here. If the cost of the Drug is less than the Covered Person's share, then the Covered Person pays 100% of the cost of the Drug. If the prescription is not covered, the Covered Person is responsible for 100% of the cost of the Drug. A Prescription Drug that is not covered may be available at a discounted price when the Covered Person shows his or her ID Card at a network pharmacy.

6.02 Schedule of Prescription Benefits

SCHEDULE OF PRESCRIPTION BENEFITS		
Prescription Benefit Maximum Out of Pocket		
Per Covered Person	$1,450	
Per Family Unit	$2,900	
	First Choice Pharmacy	**Standard Network Pharmacy**
Retail (1-30 day supply) • Generic • Preferred • Non-preferred	 $0.00 $35.00 $35.00	 $0.00 $50.00 $50.00
Mail Order (1-30 day supply) • Generic • Preferred • Non-preferred	 $0.00 $35.00 $50.00	Not Covered
Retail & Mail Order (31-60 day supply) • Generic • Preferred • Non-preferred	 $0.00 $87.50 $87.50	Not Covered
Retail & Mail Order (61-90 day supply) • Generic • Preferred • Non-preferred	 $0.00 $87.50 $87.50	Not Covered
Specialty (1-30 day supply)	$200.00	Not Covered

6.03 Prescription Drug Benefits

To be eligible for coverage as a Prescription Drug Covered Charge, Prescription Drugs, including contraceptives, must be approved by the Food and Drug Administration (FDA), prescribed in writing by a Physician as Medically Necessary for the treatment of Illness or for birth control, received as an Outpatient while the Covered Person is covered under the Plan, and purchased from a licensed Pharmacist.

New Food and Drug Administration (FDA) approved Drugs are evaluated by a pharmacy and therapeutics committee. Some Drugs may have dispensing limits that are primarily based on Food and Drug Administration (FDA)

recommendations. Additionally, some Drugs may be subject to prior authorization for Medical Necessity and the Covered Person must make sure to contact their Physician or member services to initiate authorization process.

The Plan may offer, or arrange for various entities to offer, programs, discounts, benefits or other consideration to Covered Persons for the purpose of promoting clinically appropriate Prescription Drug use. Contact member services at the phone number or website address shown on the ID Card for more information.

1. Generic Drugs (Tier 1) – Drugs on the Generic Drug list;
2. Preferred Brand Name Drugs (Tier 2) – Drugs on the preferred Brand Name Drug list; and
3. Non-preferred Brand Name Drugs (Tier 3) – Brand Name Drugs other than preferred Brand Name Drugs.

Contact member services at the phone number or website shown on the ID Card to obtain a list of network pharmacies and to access lists of covered Drugs. Information about whether a particular Drug is covered, and current Drug pricing and generic alternatives is available from a website that is accessible through the website shown on the ID Card.

Retail Network Pharmacy – Includes a nationwide network of participating retail pharmacies. When a Covered Person shows his or her ID Card at a network pharmacy, the pharmacy will collect the appropriate Covered Person's cost share and the Covered Person will not need to file a claim.

Out-of-Network Pharmacy – An Out-of-Network pharmacy is one that is not a network pharmacy.

90-Day Retail Network Pharmacy – Offers the convenience of obtaining a larger supply of a covered maintenance Prescription Drug when a prescription is filled at a designated retail network pharmacy. This option is available only after the Covered Person has filled a 30-day prescription for the same medication. To locate a designated pharmacy, contact member services at the phone number or website on the ID Card.

Mail Order Pharmacy (Home Delivery) – Offers the convenience of obtaining home delivery of insulin and covered maintenance Prescription Drugs through designated mail order pharmacies. Contact member services at the phone number or website on the ID Card for more information.

Specialty Medications – Certain "Specialty Medications" may ***only*** be obtained from designated specialty pharmacies. Because there are limited pharmacies that carry these types of medications, these prescriptions will generally be handled through a mail service. If such medications are obtained from a regular pharmacy, they will not be covered under this Plan. Generally, the participating pharmacy will reject the prescription but will provide you information on how you can have the prescription filled at the specialty pharmacy. In some cases you will be referred to a Case Management Program. Specialty Medications include, but are not limited to, Drugs used for the treatment of:

1. Chronic Renal Disease - Oncology / Oncology Adjunct
2. Crohn's Disease - Osteoarthritis and Rheumatoid Arthritis
3. Hemophilia - Psoriasis
4. HIB Adjunct - RSV: AWP
5. Hepatitis C - Transplants
6. Immune System
7. Multiple Sclerosis

NOTE: Other miscellaneous and similar conditions maybe added from time to time.

A Covered Person should contact the Claims Administrator to obtain additional information about Plan coverage of a specific benefit, particular Drug, treatment, test or any other aspect of Plan benefits or requirements.

6.04 Premier Drug Benefit (No Cost Medications)

In some cases, medications which were previously available only with a prescription are now available over-the-counter. The Plan allows Covered Persons to acquire certain over-the-counter medications, and certain prescriptions at no cost if filled at a participating pharmacy. To review a list of over-the-counter medications that are available at no

cost, please contact the Claims Administrator or the Pharmacy Benefits Manager (PBM). The Plan Administrator in consultation with the PBM may add other medications to this Premier Drug tier.

Remember, OTC medications do not legally require a prescription, but to have OTC medications covered under your Prescription Drug benefit plan, you must obtain a written prescription from your doctor and present it to a pharmacist to be filled.

How do I get an OTC medication filled with my benefits ID Card?

1. Tell your Physician that your Prescription Drug plan covers the OTC medications;
2. Obtain a written prescription from your Physician that specifies OTC;
3. Take the OTC prescription to a pharmacy to have it filled; and
4. Tell the pharmacist that your Prescription Drug plan does offer coverage for OTC medications.

6.05 Variable Copay Program

In addition to the Plan's existing Prescription Drug coverage, the Plan has partnered with pharmaceutical manufacturers, either directly or through third-party intermediaries or foundations, to provide manufacturer copay subsidies that assist in a Covered Person's out-of-pocket costs.

Under this Program, the Covered Person's out-of-pocket cost of prescription drugs may be reduced or eliminated by a manufacturer copay subsidy. Any manufacturer copay subsidy obtained under this Program will not accumulate toward the Covered Person's Deductible Amount or Out-of-Pocket Amount Limit. Only the Covered Person's true out-of-pocket cost will accumulate toward his or her Deductible Amount or Out-of-Pocket Amount Limit. Any refund, debit card, or other subsidy received by the Covered Person prior to or after a prescription is filled may be considered a manufacturer copay subsidy. The Plan Administrator has sole discretion to determine what constitutes a manufacturer copay subsidy.

Not all prescription drugs have a manufacturer copay subsidy. If a prescription drug is not eligible for a manufacturer copay subsidy, the Covered Person's copay obligation will be the copay amount listed for the drug in the standard Prescription Drug coverage under the Plan.

6.06 Limitations

There are certain limitations that apply. Prescription Drugs, which are prescribed in conjunction with a procedure, or service which is not a Covered Charge under the Plan are not reimbursable under the Plan. The following are not Covered Charges under this Plan:

1. **Administration**. Any charge for the administration of a covered Prescription Drug;
2. **Allergy Serums**;
3. **Anti-obesity Drugs and Formulas**;
4. **Appetite Suppressants**;
5. **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device;
6. **Dosage.** More than one purchase of a Drug or insulin during the dosage period recommended by the prescribing doctor;
7. **Drugs Used for Cosmetic Purposes.** Charges for Drugs used for Cosmetic purposes, such as anabolic steroids, Retin A, or those used for hair growth and removal;
8. **Experimental and/or Investigational Drugs.** Experimental Drugs and medicines, even though a charge is made to the Covered Person, or a Drug or medicine labeled: "caution – limited by Federal law to investigational use;"
9. **Growth Hormones**;
10. **Impotence Drugs**;
11. **Infertility.** Drugs for infertility medication;
12. **Inpatient Medication**;
13. **Medical Exclusions.** A charge excluded under General Limitations and Exclusions;
14. **No Charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs;

15. **Non-FDA.** Any Drug not approved by the Food and Drug Administration (FDA);
16. **Non-Insulin Syringes**;
17. **Non-Prescription.** Over-the-Counter (OTC) Drugs and supplies, unless specifically listed in the Plan as a covered benefit; and except as required by ACA;
18. **Occupational.** Prescriptions necessitated due to an occupational activity or event occurring as a result of an activity for wage or profit which an eligible person is entitled to receive without charge under any workers' compensation or similar law;
19. **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician;
20. **Smoking Cessation Drugs.** Smoking cessation Drugs, except as required by ACA; and
21. **Vitamins**. Vitamins, except pre-natal vitamins, or as required by ACA.

ARTICLE VII
GENERAL LIMITATIONS AND EXCLUSIONS

Some health care services are not covered by the Plan. Coverage is not available from the Plan for charges arising from the following:

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

2. **Aids/Devices.** For aids, devices or other adaptive equipment that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, Personal Digital Assistants (PDAs) Braille typewriters, visual alert systems for the deaf and memory books.

3. **Alcohol.** Services, supplies, care, or treatment involving a Covered Person who has taken part in an illegal act due to the use of alcohol. Expenses will be covered for Injured Covered Persons other than the person partaking in an activity made illegal due to the use of alcohol, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

4. **Alternative Therapies.** Including but not limited to: Acupuncture, Hypnosis, Orthometric and Orthoptics (Vision Therapies), Orthotripsy (Extracorporeal Shock Wave Treatment), Recreational Therapy, Sleep Therapy, or any other Non-Medical Therapy Services.

5. **Blood Administration.** Blood administration for the purpose of general improvement in physical condition.

6. **Broken Appointments.** Charges made by a doctor or other health care Provider for broken appointments, phone calls, email or internet evaluations unless otherwise specified as covered under the Plan.

7. **Certification Requirement.** To the extent of the exclusions imposed by any certification requirement (such as medical management requirements) shown in this Plan.

8. **Complications of Non-Covered Treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan.

9. **Consumable Medical Supplies.** Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Mastectomy and Reconstructive Surgery" benefits.

10. **Consumed on Premises.** Any Drug or medicine that is consumed or administered at the place where it is dispensed. Eligible injections administered on premises will be covered in accordance with the Plan terms.

11. **Contraceptives.** Non-Food and Drug Administration (FDA) approved Drugs and supplies, other than contraceptives prescribed for the purpose of birth control that are not Medically Necessary.

12. **Cosmetic.** Unless it is to correct a condition resulting from an accidental Injury sustained while coverage is in effect under this Plan or to correct a congenital anomaly of a Dependent Child who was covered under this Plan at the time of birth or unless otherwise specified under the Plan.

13. **Court Ordered.** Court ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this Plan.

14. **Custodial Care.** Custodial Care of a Covered Person whose health is stabilized and whose current condition is not expected to significantly or objectively improve or progress over a specified period of time. Custodial

Care does not seek a cure, can be provided in any setting and may be provided between periods of acute or inter-current health care needs. Custodial Care includes any skilled or non-skilled health services or personal comfort and convenience services which provide general maintenance, supportive, preventive and/or protective care. This includes assistance with, performance of or supervision of;

a. walking, transferring or positioning in bed and range of motion exercises;
b. self-administered medications;
c. meal preparation and feeding by utensil, tube or gastronomy;
d. oral hygiene, skin and nail care, toilet use, routine enemas;
e. nasal oxygen applications;
f. dressing changes;
g. maintenance of in-dwelling bladder catheters; or
h. general maintenance of colostomy, ileostomy, gastronomy, tracheostomy and casts.

15. **Dental Services or Supplies.** Charges for dental services or supplies of any kind under the medical benefit provisions of the Plan. Dental services or supplies mean those performed or provided in connection with treatment to alter, correct, fix, improve, remove, replace, reposition, or treat:

    a. teeth;
    b. the gums and tissues around the teeth;
    c. the parts of the upper or lower jaws which contain teeth (the alveolar processes and ridges);
    d. the jaw, or any jaw implant;
    e. the meeting of upper and lower teeth; or
    f. the chewing muscles.

    These are dental services or supplies even if they are needed because of symptoms, Sickness, or Injury which affect some other part of the body. Dental services or supplies also include any other services or supplies performed or provided in connection with any examination or treatment of the teeth, gums, jaw, or chewing muscles, because of pain, Injury, decay, malformation, Disease, or infection.

16. **Donation of Blood.** Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the medical management review opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

17. **Enteral Feedings.** Enteral feedings, supplies and specially formulated medical foods that are prescribed and non-prescribed, unless specifically provided in the enteral nutrition benefit.

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

19. **Excess Charges.** Charges for any care, supplies, treatment, and/or services that exceed Plan limits set forth herein and including, but not limited to, the Maximum Allowable Charge. This shall include charges that are in excess of the Medicare Approved Amount or are for services not deemed to be Medically Necessary, in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

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

21. **Experimental.** Charges for any care, supplies, treatment, and/or services that are Experimental or Investigational.

22. **Eye Care.** Charges for or in connection with eye refractions, eye glasses, keratoplasty, radial keratotomy or keratectomy, or any surgical correction of vision which is correctable through conventional means (glasses or lenses), contact lenses, or examinations for the fitting or prescription of such, except examinations required as the result of an accidental Injury or Illness occurring while covered by this Plan. Charges made for therapy or training relating to muscular imbalance of the eye (orthoptics) that does not have a disease etiology.

23. **Foreign Travel.** Care, treatment or supplies out of the U.S. if travel is for the purpose of obtaining medical services, unless otherwise approved by the Plan Administrator.

24. **Genetic Screening.** Genetic screenings or pre-implantation genetic screenings, except to the extent they are required under the Affordable Care Act (ACA). General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.

25. **Government Coverage.** Any Hospital confinement, surgery, treatment, services or supplies which are payable by or through any plan or program of any government or governmental agency. For the purpose of this paragraph, a Covered Person who at any time was entitled to enroll in the entire Medicare Program but who did not do so will be considered to be entitled to reimbursement in an amount equal to the amount to which he or she would have been entitled if so enrolled. The term "any government" includes Federal, State, provincial, or local government or any political subdivisions thereof of the United States, or any country. This provision is subject to any provisions or regulations of such plan or program which requires that group benefits be utilized before benefits are available there under.

26. **Growth Hormones.** For provision of human or synthetic growth hormones, except for growth hormones required due to the removal of the pituitary gland, which will be reviewed for coverage.

27. **Hair Loss.** Charges for hair loss, including wigs, hair transplants or any Drug that promises hair growth, whether or not prescribed by a Physician. Two wigs will be a covered charge during each Calendar Year if it is required due to hair loss from chemotherapy or radiation.

28. **Home Modifications.** Expenses for modification of home or living quarters due to medical disabilities.

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

30. **Illegal Acts.** Charges for care, supplies, treatment, and/or services for any Injury or Sickness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

31. **Illegal Drugs or Medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness Incurred while the Covered Person was voluntarily taking or was under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician, or of any Schedule I substance, even if administered on the advice of a Physician and/or legal under the law of the state where the Participant lives. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

32. **Immunizations.** Charges for immunizations not otherwise specifically provided herein.

33. **Incurred by Other Persons.** Charges for any care, supplies, treatment, and/or services for expenses Incurred by other persons.

34. **Incomplete Statements.** Charges contained in statements which are incomplete. The documentation submitted by a Covered Person must include itemized statements identifying the patient, date of treatment, diagnosis and type of service provided, and charge for each service. Examples of unacceptable statements are photocopies, cash register receipts, canceled checks and similar documents.

35. **Infertility Services.** Infertility testing, (except as described in the Infertility Testing provision), infertility services, infertility Drugs, surgical or medical treatment programs for infertility, including in-vitro fertilization, gamete intrafallopian transfer (GIFT) zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from the coverage.

36. **Medical Necessity.** Charges for care, supplies, treatment, and/or services that are not Medically Necessary.

37. **Membership Costs.** Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.

38. **Negligence.** Any charge for care, supplies, treatment, and/or services for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.

39. **Newborn of a Dependent Child.** Any charge for the care, supplies, treatment, and/or services for the newborn of a Dependent Child.

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

41. **No Coverage.** Charges which would not have been made if the Covered Person did not have coverage.

42. **No Obligation to Pay.** Charges which the Covered Person is not obligated to pay, or for which the Covered Person is not billed, or for which the Covered Person would not have been billed except that they were covered under the Plan.

43. N**o Physician Recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

44. **Non-Compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

45. **Non-Emergency Hospital Admissions.** Weekend Hospital admissions on Friday, Saturday, or Sunday when admission is not considered an Emergency. This does not apply if Surgery is performed within 24 hours of admission.

46. N**on-Injectable Prescription Drug.** All non-injectable Prescription Drugs, injectable Prescription Drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and Experimental and Investigational drugs, except as provided in this Plan.

47. **Non-Medical Ancillary Services.** Including but not limited to custodial services, education, training, vocational rehabilitation, behavioral training, back to school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.

48. **Non-Medical Counseling.** Including but not limited to services and treatment for bereavement, employment, family, financial, legal services, social adjustments, marriage, pastoral, pre-marital, or religious counseling.

49. **Not Acceptable.** Charges for care, supplies, treatment, and/or services that are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).

50. **Not Actually Rendered.** Charges for care, supplies, treatment, and/or services that are not actually rendered.

51. **Not Specified as Covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

52. **Nutritional Supplements.** Charges Incurred for nutritional supplements which are not necessary for the treatment of a Sickness or Injury.

53. **Occupational.** Care and treatment of an Injury or Sickness that is occupational that is, arises from work for wage or profit including self-employment.

54. **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 Payer 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.

55. **Personal Comfort or Beautification Items.** Charges Incurred for services or supplies which constitute personal comfort or beautification items or other equipment, such as, but not limited to, air conditioners, air purification units, humidifiers, cryotherapy units, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, telephone, television, nonprescription drugs and medicines, and first aid supplies and non-hospital adjustable beds use or in connection with Custodial Care, education or training (except dietary consultation or instruction for systemic diseases), arch supports, elastic stockings, garter belts, corsets, dentures, or expenses actually Incurred for other persons.

56. **Personal Injury Insurance.** That are in connection with an automobile accident for which benefits payable hereunder are, or would be otherwise covered by, mandatory no-fault automobile insurance or any other similar type of personal injury insurance required by state or federal law, without regard to whether or not the Covered Person actually had such mandatory coverage. This Exclusion does not apply if the Injured person is a passenger in a non-family owned vehicle or a pedestrian.

57. **Physical Exams.** Charges for adoption, camp, employment, flight, insurance, or school physicals.

58. **Plan Design.** For charges excluded or limited by the Plan design as stated in this document.

59. **Private Duty Nursing.** Charges for private duty nursing except as provided herein.

60. **Prohibited by Law.** Charges to the extent that payment under this Plan is prohibited by law.

61. **Provider Error.** Charges for care, supplies, treatment, and/or services required as a result of unreasonable Provider error.

62. **Public Program.** Expenses for care provided through or by a public program, to the extent that a Covered Person is in any way paid or entitled to payment for those expenses by or through the public program, other than Medicaid.

63. **Relative Giving Services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, Child, brother or sister, whether the relationship is by blood or by marriage unless performed in the normal course of business by a Provider-family member.

64. **Reports/Evaluations.** Unless otherwise covered in this Plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and Court Ordered, forensic or custodial evaluations.

65. **Routine Patient Costs for Participation in an Approved Clinical Trial**
The following items are excluded from approved clinical trial coverage under this Plan:

    a. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.
    b. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial.
    c. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.
    d. A cost associated with managing an Approved Clinical Trial.
    e. The cost of a health care service that is specifically excluded by the Plan.
    f. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research institution conducting the Approved Clinical Trial.

    If one or more participating Providers do participate in the Approved Clinical Trial, the qualified Covered Person must participate in the Approved Clinical Trial through a participating, Network Provider, if the Provider will accept the Covered Person into the trial.

    The Plan does not cover routine patient care services that are provided outside of this Plan's health care Provider Network unless Non-Network benefits are otherwise provided under this Plan.

66. **School System/School District.** Care required by State or Federal law to be supplied by a public school system or school district.

67. **Self-Inflicted.** Charges for any care, supplies, treatment, and/or services that are the result of intentionally self-inflicted Injuries or Illnesses. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

68. **Services at Employer's Premises.** Expenses for services rendered through a medical department clinic or similar facility provided or maintained by the Participating Employer.

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

70. **Sexual Dysfunction.** Charges in connection with impotence and sexual dysfunction.

71. **Smoking Cessation.** Charges for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to severe active lung Illness such as emphysema or asthma, except as required by the Affordable Care Act (ACA).

72. **Sterilization Reversal.** Reversal of male or female voluntary sterilization procedures.

73. **Subrogation, Reimbursement, and/or Third-Party Responsibility.** Charges for any care, supplies, treatment, and/or services of an Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third-party responsibility provisions.

74. **Travel or Accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge; unless specifically provided under the Plan.

75. **United States Government.** Charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Illness.

76. **Vaccines.** Charges for any vaccine except as required by the Affordable Care Act (ACA).

77. **Vitamins.** Charges for vitamins, except as specified under Preventive Care.

78. **War.** Any loss that is due to a declared or undeclared act of war.

With respect to any Illness or Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Illness or Injury if the Illness or Injury results from being the victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

ARTICLE VIII
ELIGIBILITY FOR COVERAGE

A Covered Person should contact the Claims Administrator to obtain additional information about Plan coverage of a specific benefit, particular Drug, treatment, test or any other aspect of Plan benefits or requirements.

8.01 Eligibility

8.01A Eligible Employees
A person is eligible for Employee coverage from the first day that he or she:

1. Is a full-time Active Employee of the Employer. An Employee is considered to be full time if he or she normally works at least 20 hours per week and is on the regular payroll of the Employer.
2. An Employee who is on qualified FMLA Leave shall be deemed to have continued eligibility during the FMLA Leave.
3. An Employee who is on an authorized leave under Section 10.01 shall be deemed to have continued eligibility during such leave.

8.01B Eligible Classes of Dependents
Dependent shall mean one or more of the following person(s):

1. An Employee's lawfully married spouse possessing a marriage license or common law marriage recognized by the State of domicile. The Plan Administrator may, in its sole discretion, require documentation proving a legal marital relationship;
2. An Employee's Child who is less than 26 years of age; and/or
3. An Employee's Child, regardless of age, who was continuously covered under this Plan prior to attaining the limiting age under the bullets above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age under the bullets above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age under the bullets above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan, such as proof of the Child's Total Disability and dependency, during the two years following the date the Child reaches the limiting age. After such two-year period, the Plan may require such proof, but not more often than once each year.

A Covered Person of this Plan may obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order determinations from the Plan Administrator.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the Legally Separated or divorced former spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for Deductibles and all amounts applied to maximums.

If both parents are Employees, their Children will be covered as Dependents of one parent or the other, but not of both.

It is the responsibility of the Employee to notify the Employer when a covered Dependent is no longer eligible for coverage. The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship. Such documentation may include a marriage license, tax return(s), spouse employment information, birth certificate or other similar information.

8.01C Eligibility Requirements for Dependent Coverage

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

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

8.02 Enrollment

8.02A Enrollment Requirements

An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. If Dependent coverage is desired, the covered Employee is required to enroll for Dependent coverage also.

8.02B Enrollment Requirements for Newborn Children

A newborn Child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered nursery care will be applied toward the plan of the newborn Child for 31 days. If the newborn Child is required to be enrolled and is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs after the first 31 days.

Charges for covered routine Physician care will be applied toward the plan of the newborn Child for 31 days. If the newborn Child is required to be enrolled and is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs after the first 31 days.

For coverage of Sickness or Injury, including Medically Necessary care and treatment of congenital defects, birth abnormalities or complications resulting from prematurity, the newborn Child is required to be enrolled. The Child must be enrolled as a Dependent under this Plan within 31 days of the Child's birth in order for non-routine coverage to take effect from the birth.

If the Child is required to be enrolled and is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

8.02C Timely or Late Enrollment

1. **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

   If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent Children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Service Waiting Period as long as coverage has been continuous.

2. **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period.

   If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan then, upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

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

   A Late Enrollee may apply for coverage only during an Open Enrollment Period. Coverage for a Late Enrollee who applies during the Open Enrollment Period will begin on January 1.

8.02D Special Enrollment Rights under CHIP

If an Employee has declined enrollment in the Plan for him or herself or his or her Dependents (including a spouse) because of coverage under Medicaid or the CHIP, there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

In addition, if an Employee has declined enrollment in the Plan for him or herself or his or her Dependents (including a spouse), and later becomes eligible for State assistance through a Medicaid or Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the State assistance.

8.02E Special Enrollment Periods

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

1. **Individuals losing other coverage.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to any of the following conditions:
    a. The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual;
    b. If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment;
    c. The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of Legal Separation, divorce, death, termination of employment or reduction in the number of hours of employment) or Employer contributions towards the coverage were terminated;
    d. The Employee or Dependent requests enrollment in this Plan no later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or Employer contributions, described above;
    e. For purposes of these rules, a loss of eligibility occurs if:
        i. The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (e.g., part-time employees);
        ii. The Employee or Dependent has a loss of eligibility as a result of Legal Separation, divorce, cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated; or
        iii. The Employee or Dependent has a loss of eligibility when coverage is offered through an Health Maintenance Organization (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).
        iv. The Employee or Dependent has a loss of eligibility when coverage is offered through an Health Maintenance Organization (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.

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

2. **Dependent beneficiaries.** If:

a. The Employee is a Covered Person under this Plan (or has met the Service Waiting Period applicable to becoming a Covered Person under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period); and
b. A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption; then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a Child, the spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the spouse is otherwise eligible for coverage.

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

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

a. On the date of marriage;
b. In the case of a Dependent's birth, as of the date of birth; or
c. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption; or
d. In the case of fostering the Dependent, the date of placement for fostering; or
e. In the case of legal guardianship, the date the legal guardianship is obtained; or
f. In the case of loss of other coverage, the date following the date of the loss of other coverage.

3. **Medicaid and State Child Health Insurance Programs.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:
   a. The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health program (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.
   b. The Employee or Dependent becomes eligible for assistance with payment of Employee Contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

   If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

   Coverage will become effective as of the first day of the first calendar month following the date of the loss of other coverage unless an earlier date is established by the Employer or by regulation.

8.02F Open Enrollment

Prior to the start of a Plan Year, this Plan has an Open Enrollment Period. Eligible Participants who are not covered under this Plan may enroll for coverage during Open Enrollment Periods. Employees who are enrolled will be given an opportunity to change their coverage effective the first day of the upcoming Plan Year. A Participant who fails to make an election during the Open Enrollment Period will automatically retain his or her present coverages. Coverage for Participants enrolling during an Open Enrollment Period will become effective on January 1, as long as all other eligibility requirements have been met. If the other eligibility requirements have not been met, coverage for Participants enrolling during an Open Enrollment Period will become effective as stated in the provision, “Eligible Employees”.

The terms of the Open Enrollment Period, including duration of the election period, shall be determined by the Plan Administrator, and communicated prior to the start of an Open Enrollment Period.

Open Enrollment Period shall mean the time frame specified by the Plan Administrator.

8.03 Funding

8.03A Cost of the Plan
The level of any Employee contributions is set by the Employer. The Employer reserves the right to change the level of Employee contributions at any time and in any manner.

8.04 Effective Date
An Employee will be covered under this Plan on the first day of active employment.

Before coverage can start, the Employee must:

1. Meet the eligibility requirement;
2. Meet the Active Employee requirement;
3. Meet the enrollment requirements of the Plan; and
4. Submit an application within 31 days after becoming eligible.

8.04A Active Employee Requirement
An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

8.04B Effective Date of Dependent Coverage
A Dependent's coverage will take effect on the day that the eligibility requirements are met; the Employee is covered under the Plan; and all enrollment requirements are met.

8.05 Qualified Medical Child Support Orders
The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient, not including an ex-stepchild or ex-stepchildren, who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" ("QMCSO") if such an individual is not already covered by the Plan as an eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

Alternate Recipient shall mean any Child of a Covered Person recognized under a Qualified Medical Child Support Order as having a right to enrollment under this Plan as the Covered Person's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent.

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

1. Provides for child support with respect to a Covered Person's Child or directs the Covered Person to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

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

1. Name of an issuing State agency;
2. Name and mailing address (if any) of an Employee who is a Covered Person under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the Child or Children of the Covered Person or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

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

1. The name and last known mailing address (if any) of the Covered Person and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

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

1. Contains the information set forth above in the definition of National Medical Support Notice;
    a. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives a NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;
    b. Informs the Plan Administrator that, if a group health plan has multiple options and the Employee is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the Child will be enrolled under the Plan's default option (if any); and
2. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated Dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Covered Persons and eligible Covered Persons without regard to this section, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders.

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

1. Notify the Covered Person and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the order is a QMCSO and notify the Covered Person and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator shall:

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:
    a. Whether the Child is covered under the Plan; and
    b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

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

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and
2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

A Covered Person of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

8.06 Acquired Companies

Eligible Employees of an acquired company who are Actively at Work or on approved Leave of Absence and were covered under the Prior Plan of the acquired company will be eligible for the benefits under this Plan on the date designated by the Employer. Any Service Waiting Period previously satisfied under the Prior Plan will be applied toward satisfaction of the Service Waiting Period of this Plan. In the event that an acquired company did not have a health plan, all eligible Employees will be eligible on the date designated by the Employer.

8.07 Genetic Information Nondiscrimination Act (GINA)

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

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

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

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

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

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

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

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

8.08 Use of 4980H Safe Harbor

In the event the Employer is subject to taxes under Section 4980H of the Code (Employer Shared Responsibility), and the Employer chooses to apply the IRS safe harbor methodology to determine eligibility for "variable" hour Employees, the following shall apply. If a variable hour Employee is determined to have met the eligibility requirements during a "standard measurement period," and is therefore required to be offered coverage during the subsequent "stability period", such Employee shall be deemed an eligible Employee for the entire corresponding stability period regardless of the Employee's hours of service. The Employer shall maintain adequate records to document the policies and procedures utilized by the Employer in applying the IRS safe harbor. The IRS regulations issued under Section 4980H describing the safe harbor, and any subsequent regulations related to the same, shall be used for the applicable definition of the terms listed above.

ARTICLE IX
TERMINATION OF COVERAGE

9.01 When Employee Coverage Terminates

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

1. The date the Plan is terminated.
2. The last day of the calendar month in which the covered Employee ceases to be in one of the eligible classes. This includes death or termination of active employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, Leave of Absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.
3. The last day of the calendar month for which the required contribution has been paid if the charge for the next period is not paid when due.
4. If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan Administrator's discretion, or may immediately terminate coverage.

9.02 When Dependent Coverage Terminates

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

1. The date the Plan or Dependent coverage under the Plan is terminated.
2. The last day of the calendar month in which the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA).
3. The last day of the calendar month in which that a covered spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA).
4. The last day of the calendar month in which a Dependent Child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA).
5. The last day of the calendar month in which the first contribution toward Dependent coverage that the Employee or Employer fails to make.

ARTICLE X
CONTINUATION OF COVERAGE

10.01 Employer Continuation Coverage
A person may remain eligible for a limited time if active, full-time work ceases due to disability, Leave of Absence, or layoff. This continuance will end as follows:

1. Short-Term Disability Leave; coverage will continue for 180 days following termination of Active Employment.
2. Leave of Absence (not meeting the definition of a FMLA Leave); coverage will continue for 2 years.

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. 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.

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

10.02 Continuation of Coverage under Federal Laws and Regulations
If coverage would otherwise terminate under this Plan, the Employee and Dependents may be eligible to continue coverage under certain Federal laws and regulations.

10.03 Continuation During FMLA Leave
See the Plan Administrator for a copy of the FMLA policy.

10.04 Employees on Military Leave
Employees going into or returning from military service may elect to continue Plan coverage as mandated by USERRA under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

1. The 24-month period beginning on the date on which the person's absence begins; or
2. The day after the date on which the person was required to apply for or return to a position of employment and fails to do so;

A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan; except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

An exclusion or Service Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Service Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, the Employee should contact the Plan Administrator, San Felipe Del Rio Consolidated Independent School District, 315 Griner Street, Del Rio, TX 78840, 1-830-778-4011. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

10.05 Continuation Coverage Rights Under COBRA

Under Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Covered Persons and their eligible family members (called Qualified Beneficiaries) covered under the Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Covered Persons and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. This notice is intended to reflect the law and does not grant or take away any rights under the law.

COBRA continuation coverage for the Plan is administered by The Kempton Group Administrators, Inc., 13431 Broadway Ext., Suite 130, Oklahoma City, Oklahoma 73114, 800-521-1711. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Claims Administrator, as the designee for the Plan Administrator, to Covered Persons who become Qualified Beneficiaries (as defined below) under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Covered Persons and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated Active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the spouse of a covered Employee, or a Dependent Child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event;
2. Any Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an Alternate Recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event; and
3. A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the spouse, surviving spouse or Dependent Child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the spouse, surviving spouse or Dependent Child was a beneficiary under the Plan.

The term "covered Employee" includes not only common law employees (whether part time or full time) but also any individual who is provided coverage under the Plan due to his or her performance of Services for the Employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a spouse or Dependent Child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Covered Person would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

1. The death of a covered Employee;
2. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment;
3. The divorce or Legal Separation of a covered Employee from the Employee's spouse;
4. A covered Employee's enrollment in any part of the Medicare program; or
5. A Dependent Child's ceasing to satisfy the Plan's requirements for a Dependent Child (e.g., attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered spouse or a Dependent Child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the spouse or a Dependent Child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under FMLA does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA Leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA Leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA Leave.

What factors should be considered when determining to elect COBRA continuation coverage? The Covered Person should take into account that the Covered Person has special enrollment rights under Federal law (HIPAA). The Covered Person has the right to request special enrollment in another group health plan for which the Covered Person are otherwise eligible (such as a plan sponsored by the Employee's spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. The Covered Person will also have the same special right at the end of COBRA continuation coverage if the Covered Person obtains COBRA continuation coverage for the maximum time available to the Covered Person.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60-day period, all rights to elect COBRA continuation coverage are forfeited.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

1. The end of employment or reduction of hours of employment;
2. Death of the Employee;
3. Commencement of a proceeding in bankruptcy with respect to the Employer; or
4. Enrollment of the Employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or Legal Separation of the Employee and spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), the Covered Person or someone on the Covered Person's behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or Dependent Child who loses coverage will not be offered the option to elect continuation coverage.

NOTICE PROCEDURES:

Any notice that the Covered Person provides must be ***in writing***. Oral notice, including notice by telephone is not acceptable. The Covered Person must mail, fax, or hand-deliver the Covered Person's notice to the person, department, or firm listed below, at the following address:

Human Resources
315 Griner Street
Del Rio, TX 78840

If mailed, the Covered Person's notice must be postmarked no later than the last day of the required notice period. Any notice the Covered Person provides must state:

- The **name of the plan or plans** under which the Covered Person lost or are losing coverage;
- The **name and address of the Employee** covered under the Plan;
- The **name(s) and address(es) of the Qualified Beneficiary(ies)**; and
- The **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or Legal Separation**, the Covered Person's notice must include **a copy of the divorce decree or the Legal Separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their Children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. If the Employee or his or her spouse or Dependent Children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

All COBRA elections should be returned to the Claims Administrator:

The Kempton Group Administrators, Inc.
13431 Broadway Ext., Suite 130
Oklahoma City, OK 73114

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later 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 made on the date they are sent to the Claims Administrator.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

1. The last day of the applicable maximum coverage period;
2. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary;
3. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee;
4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any Other Plan;
5. The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier);
6. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
    a. (i) 29 months after the date of the Qualifying Event, or (ii) 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
    b. the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, e.g., for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension, and 29 months after the Qualifying Event if there is a disability extension;
2. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
    a. 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
    b. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment;

3. In the case of a Qualified Beneficiary who is a Child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the Child was born or placed for adoption; and
4. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36 month maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Claims Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Claims Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual, (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Claims Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Claims Administrator in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified Beneficiaries will pay up to 102% of the applicable premium, and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either, under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage

under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180 day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

Trade Reform Act and Consolidated Appropriations Act, 2021

The Consolidated Appropriations Act, 2021 has extended certain provisions of the Trade Reform Act, which created a special COBRA right applicable to certain employees who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance." These individuals can either take a Health Coverage Tax Credit (HCTC) or get advance payment of the applicable percentage of premiums paid for qualified health insurance coverage, including COBRA continuation coverage. These individuals are also entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the individual becomes eligible for assistance under the Trade Reform Act. However, this election may not be made more than six months after the date the individual's group health plan coverage ends.

A Participant's eligibility for subsidies under the Consolidated Appropriations Act, 2021, affects his or her eligibility for subsidies that provide premium assistance for coverage purchased through the Health Insurance Marketplace. For each coverage month, a Participant must choose one or the other, and if he or she receives both during a tax year, the IRS will reconcile his or her eligibility for each subsidy through his or her individual tax return. Participants may wish to consult their individual tax advisors concerning the benefits of using one subsidy or the other.

Participants may contact the Plan Administrator for additional information or if they have any questions, they may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Reform Act is available at www.doleta.gov/tradeact; for information about the Health Coverage Tax Credit (HCTC), please see: https://www.irs.gov/Credits-&-Deductions/Individuals/HCTC.

IF THE COVERED PERSON HAS QUESTIONS

If the Covered Person has questions about his or her COBRA continuation coverage, the Covered Person should contact the Claims Administrator. For more information about the Covered Person's rights, including COBRA, the HIPAA, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at https://www.dol.gov/agencies/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

KEEP THE CLAIMS ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect the Qualified Beneficiary's family's rights, the Qualified Beneficiary should keep the Claims Administrator informed of any changes in the address of family members. The Qualified Beneficiary should also keep a copy, for his or her record, of any notices sent to the Claims Administrator. It is the Qualified Beneficiary's responsibility to provide current addresses to which COBRA notices are to be mailed, otherwise all notices will be mailed to the last known address.

ARTICLE XI
COORDINATION OF BENEFITS

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

11.02 Excess Insurance
If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage. The Plan's benefits will be excess to, whenever possible:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any other source of coverage, including, but not limited to, the following:
    a. Crime victim restitution funds
    b. Civil restitution funds
    c. No-fault restitution funds such as vaccine injury compensation funds
    d. Any medical, applicable disability or other benefit payments
    e. School insurance coverage

11.03 Vehicle Limitation
When medical payments are available under any automobile insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy Deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of their names, titles or classifications.

11.04 Allowable Expenses
"Allowable Expenses" shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

11.05 Claim Determination Period
"Claim Determination Period" shall mean each Benefit Year.

11.06 Effect on Benefits:

11.06A Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan Deductibles. This Plan will always be considered secondary regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier regarding priority of payment.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
2. The rules in the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

11.06B Order of Benefit Determination

For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan;
2. The benefits of a plan which covers the person on whose expenses a claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent;
3. If the person for whom claim is made is a Dependent Child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
    a. When the parents never married, are separated, or are divorced the benefits of a plan which covers the Child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the Child as a dependent of the parent without custody; or
    b. When the parents are divorced and the parent with custody of the Child has remarried, the benefits of a plan which covers the Child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that Child as a dependent of the stepparent, and the benefits of a plan which covers that Child as a dependent of the stepparent will be determined before the benefits of a plan which covers that Child as a dependent of the parent without custody.

    Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the Child's health care expenses, the benefits of the plan which covers the Child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the Child as a dependent Child; and

4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses a claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person for the shorter period of time.

11.07 Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any Other Plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

11.08 Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

11.09 Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the Maximum Amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals

or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Covered Person or his or her Dependents. **Please see the Recovery of Payments provision above for more details.**

11.10 Exception to Medicaid

The Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

ARTICLE XII
MEDICARE

12.01 Applicable to Active Employees and Their Spouses Ages 65 and Over

An Active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

12.02 Applicable to All Other Covered Persons Eligible for Medicare Benefits

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the Article entitled "Coordination of Benefits"). If the Provider accepts assignment with Medicare, Covered Charges will not exceed the Medicare Approved Amount.

12.03 Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Covered Persons Who Are Covered Under This Plan

If any Covered Person is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

ARTICLE XIII
CLAIM PROCEDURES; PAYMENT OF CLAIMS

The procedures outlined below must be followed by Covered Persons to obtain payment of health benefits under this Plan.

13.01 Definitions
Adverse Benefit Determination shall mean any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Covered Person's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Final Internal Adverse Benefit Determination shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

Final Post-Service Appeal - A post-service appeal, which constitutes the last internal appeal available to the Claimant, to be filed with the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals. The term "Final Post-Service Appeal" shall only refer to such appeals if medical services and/or supplies have already been provided. Upon filing, adjudication and conclusion of this appeal, external review becomes available to the Claimant; otherwise in accordance with applicable terms found within the Plan Document and applicable law. The Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, reserves the right to allocate certain discretionary authority as it applies to adjudication of Final Post-Service Appeals to the Plan Appointed Claim Evaluator (PACE).

Plan Appointed Claim Evaluator (PACE) - An entity appointed by the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, with authority to make final, binding (insofar and to the same extent as a decision by the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, would be deemed to be binding), claims processing decisions in response to Final Post-Service Appeals. In instances where the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, delegates fiduciary authority to the PACE, the PACE may exercise the same level of discretionary authority as that which the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, may otherwise exercise. The PACE's fiduciary duties extend only to those determinations actually made by the PACE. The PACE may perform other tasks on behalf of and in consultation with the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, but the PACE shall only be deemed to be a fiduciary when making final determinations regarding plan coverage and claims examined via Final Post-Service Appeal. The PACE shall at all times strictly abide by and make determination in accordance with the terms of the Plan and applicable law, in light of the facts, law, medical records, and all other information submitted to the PACE.

13.02 Health Claims
All claims and questions regarding health claims should be directed to the Claims Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Covered Person is entitled to them. The

responsibility to process claims in accordance with the Plan Document may be delegated to the Claims Administrator; provided, however, that the Claims Administrator is not a Fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

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

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions**. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

Benefits will be payable to a Covered Person, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

A Covered Person has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a Final Internal Adverse Benefit Determination. If the Covered Person receives notice of a Final Internal Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Covered Person then has the right to request an independent external review. The external review process is described below.

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

For Plan reimbursements, ALL BILLS MUST SHOW:

1. Group name;
2. Employee's name and ID number;
3. Patient's name and date of birth;
4. Name, address, telephone number of the provider of care;
5. Provider of care tax identification number and National Provider Identification (NPI) number;
6. Type of services rendered, with diagnosis and procedure codes;
7. Date of services; and
8. Charges.

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

1. Pre-Service Claims. A "Pre-Service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

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

   If the Plan does not require the Covered Person to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The Covered Person simply follows the Plan's procedures with

respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

2. Concurrent Claims. A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:
    a. The Plan Administrator determines that the course of treatment should be reduced or terminated; or
    b. The Covered Person requests extension of the course of treatment beyond that which the Plan Administrator has approved.

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

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

13.02A When Health Claims Must Be Filed

Claims should be filed as soon as possible with the Claims Administrator. Claims must be filed with the Claims Administrator within 12 months of the date charges for the services were Incurred. Benefits are based on the Plan's provisions at the time the charges were Incurred. **Claims filed later than that date shall be denied.**

A Pre-Service Claim (including a Concurrent Claim that also is a Pre-Service Claim) is considered to be filed when the request for approval of treatment or services is received by the Claims Administrator in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days from receipt by the Covered Person of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

13.02B Timing of Claim Decisions

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

1. Pre-Service Urgent Care Claims:
    a. If the Covered Person has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
    b. If the Covered Person has not provided all of the information needed to process the claim, then the Covered Person will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
    c. The Covered Person will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of:
        i. The Plan's receipt of the specified information; or
        ii. The end of the period afforded the Covered Person to provide the information.
    d. If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Covered Person. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Covered Person by telephone, facsimile, or other similarly expeditious method. Alternatively, the Covered Person may request an expedited review under the external review process.
2. Pre-Service Non-Urgent Care Claims:
    a. If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after

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

b. If the Covered Person has not provided all of the information needed to process the claim, then the Covered Person will be notified as to what specific information is needed as soon as possible. The Covered Person will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Covered Person (if additional information was requested during the extension period).

3. Concurrent Claims:
   a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Covered Person of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Covered Person will be notified sufficiently in advance of the reduction or termination to allow the Covered Person to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
   b. Request by Covered Person Involving Urgent Care. If the Plan Administrator receives a request from a Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Covered Person makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Covered Person submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the Urgent Care timeframe.
   c. Request by Covered Person Involving Non-Urgent Care. If the Plan Administrator receives a request from the Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-Service Non-Urgent Claim or a Post-Service Claim).
   d. Request by Covered Person Involving Rescission. With respect to rescissions, the following timetable applies:
      i. Notification to Covered Person 30 days
      ii. Notification of Adverse Benefit Determination on appeal 30 days
4. Post-Service Claims:
   a. If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
   b. If the Covered Person has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Covered Person will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Covered Person will be notified of the determination by a date agreed to by the Plan Administrator and the Covered Person.
5. Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-Service Urgent Care Claims.
6. Extensions – Pre-Service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
7. Extensions – Post-Service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

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

13.02C Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Covered Person with a notice, either in writing or electronically (or, in the case of Pre-Service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice). The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the Covered Person. The notice will contain the following information:

1. Information sufficient to allow the Covered Person to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. A reference to the specific portion(s) of the Plan provisions upon which a denial is based;
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
4. A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;
5. A description of the Plan's review procedures and the time limits applicable to the procedures.
6. A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Covered Person's claim for benefits;
7. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
8. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Covered Person, free of charge, upon request;
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Covered Person, free of charge, upon request; and
10. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable Federal law to assist individuals with the internal claims and appeals and external review processes.
11. In a claim involving Urgent Care, a description of the Plan's expedited review process.

13.03 Reconsideration of Claims

If you receive an Adverse Benefit Determination for which you believe additional information should be considered, you should refile your claim with the additional information and request the Claims Administrator to reconsider the original claim in view of the new information. The Claims Administrator will reprocess the claim and either pay it or issue you another Explanation of Benefits stating the reason for the Adverse Benefit Determination of the claim.

13.04 Appeal of Adverse Benefit Determination

13.04A Full and Fair Review of All Claims

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

1. A 180-day timeframe following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. The Plan will not accept appeals filed after a 180-day timeframe;
2. Covered Persons the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

3. Covered Persons the opportunity to review the claim file and to present evidence and testimony as part of the internal claims and appeals process;
4. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate Named Fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
5. For a review that takes into account all comments, documents, records, and other information submitted by the Covered Person relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
6. That, in deciding an appeal of any Adverse Benefit Determination which is based in whole or in part upon a medical judgment, the Plan Fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;
7. Upon request, the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;
8. If applicable, a discussion of the basis for disagreeing with the disability determination made by either (a) the Social Security Administration; or (b) an independent medical expert that has conducted a full medical review of the claimant if presented by the claimant in support of the claim.
9. That a Covered Person will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim in possession of the Plan Administrator or Claims Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Covered Person's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances; and
10. That a Covered Person will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Covered Person to respond to such new evidence or rationale.

13.04B Requirements for Appeal

The Covered Person must file the appeal in writing (although oral appeals are permitted for Pre-Service Urgent Care Claims) within 180 days following receipt of the notice of an Adverse Benefit Determination.

Pre-Service Urgent Care Claims. Oral appeals should be submitted in writing as soon as possible after the appeal has been initiated.

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

The Kempton Group Administrators, Inc.
13431 Broadway Ext., Suite 130
Oklahoma City, OK 73114
Fax: 405-521-9804
www.kemptongroup.com

It shall be the responsibility of the Covered Person or authorized representative to submit an appeal under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Covered Person;
2. The Employee/Covered Person's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits;
5. A statement in clear and concise terms of the reason(s) for disagreement with the handling of the claim; and

6. Any material or information that the Covered Person has which indicates that the Covered Person is entitled to benefits under the Plan.

13.04C Timing of Notification of Benefit Determination on Review
The Plan Administrator shall notify the Covered Person of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal;
2. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal;
3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim: Pre-service Urgent, Pre-service Non-urgent or Post-service; and
4. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal. ***NOTE:*** This timeframe is reduced to no later than 30 days per internal appeal should the Plan allow for two levels of internal appeal.

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

13.04D Manner and Content of Notification of Adverse Benefit Determination on Review
The Plan Administrator shall provide a Covered Person with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on Review, setting forth:

1. Information sufficient to allow the Covered Person to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. A reference to the specific portion(s) of the Plan provisions upon which a denial is based;
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;
4. A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;
5. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
6. A description of the Plan's review procedures and the time limits applicable to the procedures.
7. A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits;
8. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided);
9. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Covered Person, free of charge, upon request;
10. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Covered Person, free of charge, upon request; and
11. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist Covered Persons with the internal claims and appeals and external review processes.

12. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

13.04E Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

13.04F Decision on Review
The decision by the Plan Administrator or other appropriate Named Fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

13.04G Requirements for Second Level Appeal
The claimant must file an appeal regarding a Post-Service claim and applicable Adverse Benefit Determination in writing within 60 days following receipt of the notice of the first level Adverse Benefit Determination.

13.04H Two Levels of Appeal
This Plan requires two levels of appeal by a claimant before the Plan's internal appeals are exhausted. For each level of appeal, the claimant and the Plan are subject to the same procedures, rights, and responsibilities as stated within this Plan. Each level of appeal is subject to the above-outlined submission and response guidelines.

Once a claimant receives an Adverse Benefit Determination in response to an initial claim for benefits, the claimant may appeal that Adverse Benefit Determination, which will constitute the initial appeal. If the claimant receives an Adverse Benefit Determination in response to that initial appeal, the claimant may appeal that Adverse Benefit Determination as well, which will constitute the final internal appeal. If the claimant receives an Adverse Benefit Determination in response to the claimant's second appeal, such Adverse Benefit Determination will constitute the Final Internal Adverse Benefit Determination, and the Plan's internal appeals procedures will have been exhausted.

13.04I External Review Process
The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a Claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.
2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.
3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

<u>Standard external review</u>

Standard external review is external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

1. Request for external review. The Plan will allow a Covered Person to file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of a Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
2. Preliminary review. The Plan will complete a preliminary review of the request within five business days following the date of receipt of the external review request to determine whether:
    a. The Covered Person is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
    b. The Adverse Benefit Determination or the Final Internal Adverse Benefit Determination does not relate to the Covered Person's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
    c. The Covered Person has exhausted the Plan's internal appeal process (unless the Covered Person is not required to exhaust the internal appeals process under the final regulations) and rendered the appeal available for standard external review; and
    d. The Covered Person has provided all the information and forms required to process an external review. The Plan will issue a notification in writing to the Covered Person within one business day after completion of the preliminary review. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Covered Person to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.
3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Administrator to contract with, on its behalf) at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.
4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. Request for expedited external review. The Plan will allow a Covered Person to make a request for an expedited external review with the Plan at the time the Covered Person receives:
    a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Covered Person for which the timeframe for completion of a standard internal appeal under the final regulations would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function and the Covered Person has filed a request for an expedited internal appeal; or
    b. A Final Internal Adverse Benefit Determination, if the Covered Person has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Covered Person received Emergency Services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the Covered Person of its eligibility determination.
3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

Notice of final external review decision.

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

13.05 Deemed Exhaustion of Internal Claims Procedures and De Minimis

Exception to the Deemed Exhaustion Rule
A Covered Person will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Covered Person may proceed immediately to the external review program or make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the Covered Person must adhere to them before participating in the external review program or bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the Covered Person as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Covered Person, and the violation is not reflective of a pattern or practice of non-compliance.

If a Covered Person believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Covered Person may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten days. If the external reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the Plan will provide the Covered Person with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

Final Internal Adverse Benefit Determination
Upon receipt, review, adjudication and conclusion of a Final Post-Service Appeal, if it is determined by the Plan fiduciary – either the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, or the PACE – that benefits and/or coverage is not available from the Plan as it relates to claims for benefits submitted to the Plan; when such a final Adverse Benefit Determination is made, by either the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, or the PACE, the determination will be final and binding on all interested parties.

13.06 Appointment of Authorized Representative

A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a Provider will not constitute appointment of that Provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. However, in

connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

13.07 Payment of Benefits

All benefits under this Plan are payable, in U.S. dollars, to the covered Employee whose Sickness or Injury, or whose covered Dependent's Sickness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or Institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

13.07A Assignments

For this purpose, the term "Assignment of Benefits" (or "AOB") is defined as an arrangement whereby a Covered Person of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less Deductible, Copayments and Coinsurance amounts, to a medical Provider. If a Provider accepts said arrangement, the Provider's rights to receive Plan benefits are equal to those of the Covered Person, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an AOB and Deductibles, Copayments, and Coinsurance amounts, as consideration in full for treatment rendered.

The Plan Administrator may revoke an AOB at its discretion and treat the Covered Person of the Plan as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Covered Person to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Covered Person, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the Covered Person, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No Covered Person shall at any time, either during the time in which he or she is a Covered Person in the Plan, or following his or her termination as a Covered Person, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. A medical Provider which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

13.07B Non-U.S. Providers

Medical expenses for care, supplies, or services which are rendered by a Provider whose principal place of business or address for payment is located outside the United States (a "Non-U.S. Provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

1. Benefits may not be assigned to a Non-U.S. Provider;
2. The Covered Person is responsible for making all payments to Non-U.S. Providers, and submitting receipts to the Plan for reimbursement;
3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred date;
4. The Non-U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
5. Claims for benefits must be submitted to the Plan in English.

13.07C Recovery of Payments

Occasionally, benefits are:

1. paid more than once;
2. paid based upon improper billing or a misstatement in a proof of loss or enrollment information;
3. not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan; or

4. later found to be greater than the Maximum Allowable Charge.

In any of the above cases, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Covered Person on whose behalf such payment was made.

A Covered Person, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, current ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, Provider or other person or entity to enforce the provisions of this section, then that Covered Person, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Covered Persons, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Covered Persons) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Covered Person(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. in error;
2. pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. with respect to an ineligible person;
5. in anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Third-Party Recovery, Subrogation and Reimbursement provisions; or
6. pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by an Employee or by any of his covered Dependents if such payment is made with respect to the Employee or any person covered or asserting coverage as a Dependent of the Employee.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

13.07D Medicaid Coverage

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

13.08 Rescission of Coverage

A Covered Person's health coverage may not be rescinded (retroactively terminated) unless:

1. The Employer or Covered Person (or a person seeking coverage on behalf of the Covered Person) performs an act, practice or omission that constitutes fraud; or
2. The Employer or Covered Person (or a person seeking coverage on behalf of the Covered Person) makes an intentional misrepresentation of material fact.

13.09 Limitation of Action

A claimant cannot bring any legal action against the Plan for a claim of benefits until 90 days after all appeal processes have been exhausted. After 90 days, if the claimant wants to bring a legal action against the Plan, he or she must do so within three (3) years of the date he or she is notified of the final decision on the final appeal or he or she will lose any rights to bring such an action against the Plan.

ARTICLE XIV
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

14.01 Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of 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, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to crime victim restitution funds, no-fault restitution funds (including vaccine injury compensation funds), uninsured motorist, underinsured motorist, medical payment provisions, third-party assets, third-party insurance, and/or guarantor(s) of a third party, any medical, applicable disability, or other benefit payments, and school insurance coverage (collectively "Coverage").
2. 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 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) agree 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 copayee on any and all settlement drafts.
3. 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). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s) for charges Incurred up to the date such Coverage or third-party is fully released from liability, including any such charges not yet submitted to the Plan. 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. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.
4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

14.02 Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue 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, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.
2. If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable 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 Covered Person is obligated to notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
3. The Plan may, at its discretion, 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.
4. If the Covered Person(s) fails to file a claim or pursue damages against:

a. The responsible party, its insurer, or any other source on behalf of that party.
b. Any first-party insurance through medical payment coverage, personal injury protection, No-Fault Auto Insurance, uninsured or underinsured motorist coverage.
c. Any policy of insurance from any insurance company or guarantor of a third party.
d. Workers' compensation or other liability insurance company.
e. 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.

14.03 Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Covered Person(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Covered Person(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. 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. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions.
2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan. Additionally, the Covered Person shall indemnify the Plan against any of the Covered Person attorney's fees, costs, or other expenses related to the Covered Person recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent.
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).
5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

14.04 Excess Insurance

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

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.

2. Any first-party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source of coverage, including, but not limited to, the following:
    a. Crime victim restitution funds
    b. Civil restitution funds
    c. No-fault restitution funds such as vaccine injury compensation funds
    d. Any medical, applicable disability or other benefit payments
    e. School insurance coverage.

14.05 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.

14.06 Wrongful Death

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

14.07 Obligations

1. It is the Covered Person's/Covered Persons' obligation at all times, both prior to and after payment of medical benefits by the Plan:
    a. 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.
    b. 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.
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
    d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
    e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
    f. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
    g. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
    h. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.
    i. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
    j. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
    k. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.
2. If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, 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).

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

14.08 Offset

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

14.09 Minor Status

1. In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
2. 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.

14.10 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 with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

14.11 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.

ARTICLE XV
MISCELLANEOUS PROVISIONS

15.01 Applicable Law
This is a self-funded benefit plan. The Plan is funded with Employee and/or Employer contributions. When applicable, Federal law and jurisdiction preempt State law and jurisdiction.

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

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

15.03 Conformity with Applicable Laws
This Plan shall be deemed to automatically be amended to conform as required by any applicable law, equitable principal, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or statutes of limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document.

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

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person of the Plan;
2. Attempting to file a claim for a Covered Person for services which were not rendered or Drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

15.05 Headings
The headings used in this Plan Document are used for convenience of reference only. Covered Persons are advised not to rely on any provision because of the heading.

15.06 No Waiver or Estoppel
No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

15.07 Plan Contributions
The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Covered Person.

The Employer shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Employer shall be free to determine the manner and means of

funding the Plan. The amount of the Covered Person's contribution (if any) will be determined from time to time by the Employer.

15.08 Right to Receive and Release Information
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Covered Person for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

15.09 Written Notice
Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

15.10 Right of Recovery
In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the Maximum Amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Covered Person or his or her Dependents. **See the Recovery of Payments provision above for full details.**

15.11 Funding the Plan and Payment of Benefits
The cost of the Plan is funded as follows:

> **For Employee and Dependent Coverage:** Funding is derived from the funds of the Employer and contributions made by the covered Employees.
>
> The level of any Employee contributions will be set by the Employer. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Employers' accounts or trust account, if any.

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

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

15.13 Protection against Creditors
No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Covered Person, the Plan Administrator in its sole discretion may terminate the interest of such Covered Person or former Covered Person in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Covered Person or former Covered Person, his or her spouse, parent, adult Child,

guardian of a minor Child, brother or sister, or other relative of a Dependent of such Covered Person or former Covered Person, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

ARTICLE XVI
DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in this Definitions section, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Definitions section will help to better understand the provisions of this Plan.

The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Plan Document for that information.

ACA shall mean the Affordable Care Act which is the comprehensive health care reform law enacted in March 2010.

Accident is any bodily Injury caused by an Accident (a happening that is not expected, foreseen or intended, and is exact as to time and place) and which results directly from the Accident, independent of all other causes.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Actively at Work shall mean an Employee is "Actively at Work" or in active employment on any day the Employee performs in the customary manner all of the regular duties of employment. An Employee will be deemed Actively at Work on each day of a regular paid vacation or on a regular non-working day, provided the covered Employee was Actively at Work on the last preceding regular workday. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor, as defined by HIPAA, subject to the Plan's Leave of Absence provisions (including any State-mandated leave). An Employee will not be considered under any circumstances Actively at Work if he or she has effectively terminated employment.

Activities of Daily Living shall mean activities the Covered Person usually does during a normal day including but not limited to bathing, dressing, eating, grooming, maintaining continence, toileting, transferring, and mobility.

ADA shall mean the American Dental Association.

Affiliated Companies are those under common control through stock ownership or contract.

Age Discrimination is subject to any changes in the Social Security Act; all Active Employees age 65 and over are entitled to the same and /or equal benefits as those Active Employees under age 65.

AHA shall mean the American Hospital Association.

Allowable Expense shall mean the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some Other Plan provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

Alternate Recipient shall mean any Child of a Covered Person recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Covered Person's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent.

AMA shall mean the American Medical Association.

Ambulatory Surgical Center shall mean any public or private State licensed and approved (whenever required by law) establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and registered professional nursing service whenever a patient is in the facility, and which does not provide service or other accommodations for patients to stay overnight.

Approved Clinical Trial means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health, Centers for Disease Control and Prevention (CDCP), Agency for Health Care Research, Centers for Medicare and Medicaid Services (CMS), Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by National Institutes of Health (NIH) guidelines) or is conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

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

A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate, or the Covered Person provides medical and scientific information establishing that their participation is appropriate.

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

Benefit Year shall mean Calendar Year.

Birthing Center shall mean any freestanding health facility, place, professional office or Institution which is not a Hospital or in a Hospital, where births occur in a home like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

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

Brand Name (Formulary) shall mean a trade name medication.

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

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

1. It is solely for the treatment of patients who require special medical attention because of their critical condition;
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
4. It contains at least two beds for the accommodation of critically ill patients; and
5. It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

Centers of Excellence shall mean Medical Care Facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates.

Certified IDR Entity shall mean an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

Child and/or **Children** shall mean:

1. The Employee's own blood descendant of the first degree.
2. The Employee's lawfully adopted Child.
3. A Child placed with a covered Employee in anticipation of adoption which refers to:
    a. A Child whom the Employee intends to adopt.
    b. Whether or not the adoption has become final.
    c. Who has not attained the age of 18 as of the date of such placement for adoption.
    d. The Child must be available for adoption and the legal process must have commenced.

    The term placed means: The assumption and retention by such Employee of a legal obligation for total or partial support of the Child in anticipation of adoption of the child.
4. An Alternate Recipient.
5. Any stepchild of the Employee.
6. An "eligible foster child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction,
7. Any other Child who is primarily dependent on the Employee for support and maintenance, lives with the Employee in a regular parent-child relationship and is related to the Employee by blood or marriage, or
8. Any other Child for whom the Employee has obtained legal guardianship. A "legal guardian" is a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

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

CHIPRA refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

Claimant shall mean a Participant of the Plan, or entity acting on his or her behalf, authorized to submit claims to the Plan for processing, and/or appeal an Adverse Benefit Determination.

Claims Administrator shall mean the entity which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to any claims. The Claims Administrator is not an insurer of health benefits under this Plan, is not a fiduciary of the Plan, and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator. The Claims Administrator is not responsible for Plan financing and does not guarantee the availability of benefits under this Plan.

Clean Claim is a claim that can be processed in accordance with the terms of this document:

1. Without obtaining additional information from the service Provider or a third party,
2. A claim which has no defect or impropriety,
    a. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or
    b. A particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and
3. Only as permitted by this document.

A Clean Claim does not include:

1. Claims under investigation for fraud and abuse,
2. Claims under review for Medical Necessity,
3. Fees under review for being in excess of the Maximum Allowable Charge, or

Any other matter that may prevent the charge(s) from being Covered Charges in accordance with the terms of this document.

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

CLIA refers to the Clinical Laboratory Improvement Amendments of 1988 which are U.S. federal regulator standards that apply to all clinical laboratory testing performed on humans in the U.S., except clinical trials and basic research.

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

Coinsurance shall mean the cost-sharing, expressed in this Plan as a percentage amount payable by the Covered Person for health care services after the Calendar Year Deductible is satisfied.

Copay or Copayment shall mean the cost-sharing, expressed in this Plan as a fixed amount paid by the Covered Person for health care services.

Cosmetic shall mean any Surgery, service, Drug or supply in which the principal purpose is to enhance or improve the appearance of a body part except when necessitated by injury.

Covered Charge(s) shall mean a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary service, treatment or supply, meant to improve a condition or Covered Person's health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the Covered Charge is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Schedule of Benefits and as set forth elsewhere in this document.

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

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

Deductible shall mean the amount of expenses for covered services that a Covered Person must pay for him or herself before the Plan will begin its payments.

Dentist shall mean a person licensed to practice dentistry.

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

1. An Employee's lawfully married spouse possessing a marriage license or common law marriage recognized by the State of domicile. The Plan Administrator may, in its sole discretion, require documentation proving a legal marital relationship;
2. An Employee's Child who is less than 26 years of age; and
3. An Employee's Child, regardless of age, who was continuously covered under this Plan prior to attaining the limiting age under the bullets above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age under the bullets above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age under the bullets above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two-year period, the Plan may require such proof, but not more often than once each year. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the Child's Total Disability and dependency.

A Covered Person of this Plan may obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the Legally Separated or divorced former spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for Deductibles and all amounts applied to maximums.

If both parents are Employees, their Children will be covered as Dependents of one parent or the other, but not of both.

It is the responsibility of the Employee to notify the Employer when a covered Dependent is no longer eligible for coverage. The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship. Such documentation may include a marriage license, tax return(s), spouse employment information, birth certificate or other similar information.

NOTE: Tax treatment for certain dependents. Federal tax law generally does not recognize former spouses, Legally Separated spouses, civil union or domestic partners, or the children of these partners, as dependents under the federal tax code unless the spouse, partner, or child otherwise qualifies as a dependent under the Internal Revenue Code §152. Therefore, the Employer may be required to automatically include the value of the health care coverage provided to any of the aforementioned individuals, who may be covered under this Plan as eligible Dependents, as additional income to the Employee.

Diagnostic Service shall mean a test or procedure performed for specified symptoms to detect or to monitor a Disease or condition. It must be ordered by a Physician or other professional Provider.

Disease shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any worker's compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a Sickness, Illness or Disease.

Drug shall mean a Food and Drug Administration (FDA) approved Drug or medicine that is listed with approval in the United States Pharmacopeia, National Formulary or AMA Drug Evaluations published by the American Medical Association (AMA), that is prescribed for human consumption, and that is required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription," or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law), legally obtained and dispensed by a licensed

drug dispenser only, according to a written prescription given by a Physician and/or duly licensed Provider. “Drug” shall also mean insulin for purposes of injection. The Plan Administrator in its sole discretion may deem a medication which would otherwise not meet the definition of “Drug” a Covered Expense under the Plan, provided the safety and efficacy can be reasonably confirmed, for example, a foreign version of an FDA-approved Drug.

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

Emergency shall mean a situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably be expected to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. An Emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator’s discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

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

Emergency Services shall mean, with respect to an Emergency Medical Condition, the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

Employee shall mean a person who is an Employee of the Participating Employer, who is an Active Employee, regularly scheduled to work for the Participating Employer in an Employer-Employee relationship. Such person must be scheduled to work an average of at least 20 hours per week in order to be considered an eligible Employee.

Employer is San Felipe Del Rio Consolidated Independent School District and any Affiliated Companies listed in the application of the Employer. The Employer may add an affiliated company after the Effective Date of the Plan. For that company only, the effective date of the Plan will be considered to be the effective date of the amendment that adds that company.

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

Essential Health Benefits shall mean, under section 1302(b) of the Affordable Care Act (ACA), those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Abuse Disorder services, including behavioral health treatment; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision screenings. Self-funded plans such as this Plan are not required to cover all Essential Health Benefits as listed above.

Exclusion shall mean conditions or services that this Plan does not cover.

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

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

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

1. If the Drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the Drug or device is furnished;
2. If reliable evidence shows that the Drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
    a. Maximum tolerated dose;
    b. Toxicity;
    c. Safety;
    d. Efficacy; and
    e. Efficacy as compared with the standard means of treatment or diagnosis; or
3. If reliable evidence shows that the consensus among experts regarding the Drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
    a. Maximum tolerated dose;
    b. Toxicity;
    c. Safety;
    d. Efficacy; and
    e. Efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same Drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same Drug, device, or medical treatment or procedure.

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

Subject to a medical opinion, if no other Food and Drug Administration (FDA) approved treatment is feasible and as a result the Covered Person faces a life or death medical condition, the Plan Administrator retains discretionary authority to cover the services or treatment.

Explanation of Benefits ("EOB") is a statement a health plan sends to a Covered Person which shows charges, payments and any balances owed. An Explanation of Benefits may serve as an Adverse Benefit Determination.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Fiduciary shall mean the Plan Administrator.

Final Internal Adverse Benefit Determination shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

FMLA shall mean the Family and Medical Leave Act of 1993, as amended. Contact the Employer for a copy of the FMLA policy.

FMLA Leave shall mean a Leave of Absence, which the Company is required to extend to an Employee under the provisions of the FMLA. Contact the Employer for a copy of the FMLA policy.

Generic Drug shall mean a Prescription Drug which has the equivalency of the Brand Name Drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

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

Habilitation/Habilitative Services shall mean health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

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

Home Health Care shall mean the continual care and treatment of an individual if:

1. The institutionalization of the individual would otherwise have been required if Home Health Care was not provided;
2. The treatment plan covering the Home Health Care Service is established and approved in writing by the attending Physician; and
3. The Home Health Care is the result of an Illness or Injury.

Home Health Care Agency shall mean an agency or organization which provides a program of Home Health Care and which:

1. Is approved as a Home Health Agency under Medicare;
2. Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
3. Meets all of the following requirements:
    a. It is an agency which holds itself forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home;
    b. It has a full-time administrator;
    c. It maintains written records of services provided to the patient;
    d. Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and

e. Its employees are bonded and it provides malpractice insurance.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

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

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

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

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

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

Hospital shall mean an Institution that meets all of the following requirements:

1. It provides medical and Surgical facilities for the treatment and care of Injured or Sick persons on an Inpatient basis;
2. It is under the supervision of a staff of Physicians;
3. It provides 24-hour-a-day nursing service by registered nurses;
4. It is duly licensed as a Hospital, except that this requirement will not apply in the case of a State tax supported Institution;
5. It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training type Institution, or an Institution which is supported in whole or in part by a Federal government fund; and
6. It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

“Hospital” shall also have the same meaning, where appropriate in context, set forth in the definition of “Ambulatory Surgical Center.”

Identification Card or ID Card shall mean the card issued to the Covered Person by the Claims Administrator which identifies specific coverage available to the Covered Person. It also includes the telephone number that the Covered Person must call for preauthorization.

Illness and Illnesses shall mean a bodily disorder, Disease, physical Sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

In-Network shall mean the facilities, providers and suppliers who have by contract via a medical Provider network agreed to allow the Plan access to discounted fees for service(s) provided to Covered Persons, and by whose terms the network’s Providers have agreed to accept assignment of benefits and the discounted fees thereby paid to them by the Plan as payment in full for Covered Charges. The applicable Provider network will be identified on the Covered Person’s Identification Card.

Impregnation and Infertility Treatment shall mean any services, supplies or Drugs related to the Diagnosis or treatment of infertility.

Incurred shall mean that a Covered Charge is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Charges are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Charges for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Independent Freestanding Emergency Department means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

Injury and Injuries shall mean an accidental physical Injury to the body caused by unexpected external means. (Any loss which is caused by or contributed to by a hernia of any kind, sprains, strains, etc. caused by lifting, hyperextension or over exertion; or an allergic reaction to any “bite” will be considered a loss under the definition of Illness and not as a loss resulting from accidental Injury).

Inpatient shall mean a Participant who receives care as a registered and assigned bed patient while confined in a Hospital, other than in its outpatient department, where a room and board is charged by the Hospital.

Institution shall mean a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative Birthing Center, or any other such facility that the Plan approves.

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

Intensive Outpatient Services shall mean programs that have the capacity for planned, structured, service provision of at least two hours per day and three days per week. The range of services offered could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and medical monitoring. These services would include multiple or extended treatment/Rehabilitation/counseling visits or professional supervision and support. Program models include structured crisis intervention programs, psychiatric or psychosocial rehabilitation, and some day treatment.

Late Enrollee shall mean a Covered Person who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Leave of Absence shall mean a period of time during which the Employee must be away from his or her primary job with the Employer, while maintaining the status of Employee during said time away from work, generally requested by an Employee and having been approved by his or her Participating Employer, and as provided for in the Participating Employer’s rules, policies, procedures and practices where applicable.

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

Legal Separation and/or Legally Separated shall mean an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Manipulative Therapy shall mean skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Maximum Allowable Charge shall mean the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

For claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprises Bills" within the section "Summary of Benefits,") if no negotiated rate exists, the Maximum Allowable Charge will be:

- An amount determined by an applicable all-payer model agreement; or
- If no such amount exists, an amount determined by applicable state law; or
- If neither such amount exists, an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the Maximum Allowable Charge will be determined by the Plan to be the Medicare reimbursement rates presently utilized by the Centers for Medicare and Medicaid Services ("CMS") multiplied by a designated percentage:

1. Physicians and other Providers will be limited to 130% of their current Medicare Approved Amount.
2. Facilities and Hospitals will be limited to 160% of their current Medicare Approved Amount.
3. Laboratory Services will be limited to 100% of their current Medicare Approved Amount.
4. Anesthesia performed by an anesthesiologist will be limited to 250% and CRNA will be limited to 200% of their current Medicare Approved Amount.
5. Emergency Room services will be limited to 200% of their current Medicare Approved Amount.
6. Air Ambulance will be limited to 120% of their current Medicare Approved Amount.
7. Ground Ambulance will be limited to 200% of their current Medicare Approved Amount.
8. Dialysis will be limited to 240% of their current Medicare Approved Amount.

If no Medicare reimbursement rate is available for a given item of service or supply, Medicare reimbursement rates will be calculated based on one of the following:

- Prices established by CMS utilizing standard Medicare Payment methods and/or based upon supplemental Medicare or Medicaid pricing data for items Medicare doesn't cover based on data from CMS;
- Prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained providers of care; or
- Prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained providers of care in traditional settings.

If and only if none of the factors above is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare cost data, amounts actually collected by providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that

are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

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

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

1. Provides for child support with respect to a Covered Person's Child or directs the Covered Person to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

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

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

1. Its purpose must be to restore health.
2. It must not be primarily custodial in nature.
3. It is ordered by a Physician for the diagnosis or treatment of a Sickness or Injury.
4. The Plan reserves the right to incorporate CMS guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

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

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator's own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems appropriate.

Off-label Drug use may be considered Medically Necessary when all of the following conditions are met:

1. The Drug is approved by the Food and Drug Administration (FDA);
2. The prescribed Drug use is supported by one of the following standard reference sources:
    a. Micromedex® DRUGDEX®;
    b. The American Hospital Formulary Service Drug Information;
    c. Medicare approved Compendia; or

d. Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the Drug is safe and effective for the specific condition; and

3. The Drug is Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

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

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

Medicare Approved Amount shall be the Covered Charges based on the "Medicare Approved Amount" plus a percentage, for services received for Out-of-Network. *Medicare generates the Medicare Approved Amounts each year*. This does not mean you have to be a Medicare covered participant. It means only that the Medicare Approved Amount will be used by the Plan to determine the Maximum Allowable Charge for Out-of-Network Providers. *The amount will be increased as follows:*

1. Physicians and other Providers will be limited to 130% of their current Medicare Approved Amount.
2. Facilities and Hospitals will be limited to 160% of their current Medicare Approved Amount.
3. Laboratory Services will be limited to 100% of their current Medicare Approved Amount.
4. Anesthesia performed by an anesthesiologist will be limited to 250% and CRNA will be limited to 200% of their current Medicare Approved Amount.
5. Emergency Room services will be limited to 200% of their current Medicare Approved Amount.
6. Air Ambulance will be limited to 120% of their current Medicare Approved Amount.
7. Ground Ambulance will be limited to 200% of their current Medicare Approved Amount.
8. Dialysis will be limited to 240% of their current Medicare Approved Amount.

In some cases, if the service does not have a Medicare Approved Amount, the amount billed will be reduced to a Usual and Customary amount for payment by the Plan.

The Deductible and Out-of-Pocket amounts are applied to the adjusted Medicare Approved Amount.

Many Providers will accept the payment as payment-in-full from the Plan; *however, some may not.* Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the Provider does not accept the payment as payment-in-full from the Plan, the Provider may bill you for the amount it determines it is still owed. ***This is called "balance billing***." Generally, if you intend to use an Out-of-Network Provider, you may be able to negotiate the balance due from you. The amount a Provider balance bills you is *your* responsibility and is not payable by the Plan.

Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1. The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).
3. The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
4. There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

Mental or Nervous Disorder shall mean any Disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources. The fact that a disorder is listed in any of these sources does not mean that treatment of the disorder is covered by the Plan.

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

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

Nurse shall mean an individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.), and who is duly licensed by the State or regulatory agency responsible for such license in the State in which the individual performs the nursing services.

Open Enrollment Period shall mean a period of time in each Calendar Year as determined by the Plan Administrator where employees may make changes to their coverage or enroll if eligible and not covered previously.

Other Plan shall include, but is not limited to:

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

Out-of-Network shall mean the facilities, providers or suppliers which at the time that Covered Charges are Incurred, do not have a contract with the preferred provider organization.

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

Partial Hospitalization shall mean medically directed intensive, or intermediate short-term mental health and Substance Abuse treatment, for a period of less than twenty-four (24) hours but more than four (4) hours in a day in a licensed or certified facility or program.

Participating Health Care Facility shall mean a Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

Physician shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Optometrist (O.D.), Physician Assistant, (P.A.), Physiotherapist, Psychiatrist, Psychologist

(Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a State or Federal agency and is acting within the scope of his or her license.

Plan shall mean San Felipe Del Rio CISD Group Health Plan, which is a benefits plan for certain Employees of San Felipe Del Rio Consolidated Independent School District and is described in this document.

Plan Year is the 12-month period beginning on the effective date of the Plan.

PPO or **"Preferred Provider Organization"** shall mean a medical care arrangement where Physicians and facilities provide services to Covered Persons at contracted rates.

Pregnancy shall mean a physical state whereby a woman presently bears a child or children in the womb, prior to but likely to result in childbirth, miscarriage and/or non-elective abortion. Pregnancy is considered a Sickness for the purpose of determining benefits under this Plan.

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

Preventive Care shall mean certain Preventive Care services.
This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer In-Network coverage for certain preventive services without cost-sharing. To comply with ACA, and in accordance with the recommendations and guidelines, the Plan will provide In-Network coverage for:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force (USPSTF) recommendations;
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention (CDCP);
3. Comprehensive guidelines for infants, Children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found at the following websites:
https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;
https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;
https://www.hrsa.gov/womensguidelines/.
For more information, you may contact the Claims Administrator.

NOTE: The Preventive Care services identified through this link are recommended services, not mandated services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered. Preventive Care services will be covered at 100% for Out-of-Network Providers if there is no In-Network Provider who can provide a required preventive service.

Preventive services received outside the recommended Affordable Care Act (ACA) age limits or other Plan age limits are subject to the benefits listed in the Schedule of Benefits. These specific preventative services are subject to all applicable plan provisions, including limitations and exclusions.

Primary Care Physician (PCP) shall mean a health care professional who practices general medicine, which includes family practitioners, general practitioners. non-specializing internists, OBGYNs, and pediatricians. All other Physicians are considered specialists.

Prior Plan shall mean the coverage provided on a group or group-type basis by the group insurance policy, benefit plan or service plan that was terminated as of the day before the Effective Date of the Plan and replaced by the Plan.

Prior to Effective Date or After Termination Date are dates occurring before a Covered Person gains eligibility from the Plan, or dates occurring after a Covered Person loses eligibility from the Plan.

This also includes charges Incurred prior to the effective date of coverage under the Plan or after coverage is terminated, unless extension of benefits applies.

Privacy Standards shall mean the standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

Provider shall mean a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or facility defined or listed herein, or approved by the Plan Administrator.

Psychiatric Hospital shall mean an Institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a Physician;
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
3. It is licensed as a Psychiatric Hospital;
4. It requires that every patient be under the care of a Physician; and
5. It provides 24-hour-a-day nursing service.

The term Psychiatric Hospital does not include an Institution, or that part of an Institution, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care or educational care.

Qualified Medical Child Support Order or QMCSO is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Covered Person or eligible Dependent is entitled under this Plan.

Qualifying Payment Amount means the median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's Third Party Administrator (if calculated by the Third Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

Reasonable shall mean in the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) national medical associations, societies, and organizations; (b) Centers for Medicare and Medicaid Services (CMS); and (c) the Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s)

and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or service(s) resulting from Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when, taking into consideration but not limited to Center for Medicare and Medicaid Services (CMS) guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

Recognized Amount shall mean, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider's billed charge or the Qualifying Payment Amount.

Rehabilitation shall mean treatment(s) designed to facilitate the process of recovery from Injury, Illness, or Disease to as normal a condition as possible.

Rehabilitation Hospital shall mean an Institution which mainly provides therapeutic and restorative services to Sick or Injured people. It is recognized as such if:

1. It carries out its stated purpose under all relevant Federal, State and local laws;
2. It is accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities; or
3. It is approved for its stated purpose by Medicare.

Residential Treatment Facility shall mean a facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of Participants diagnosed with alcohol, drug or Substance Abuse disorders or mental illness.

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

Service Waiting Period shall mean an interval of time which the Employee is in the continuous, active employment of his or her Participating Employer.

Sickness is:
For a covered Employee and covered spouse: Illness, Disease or Pregnancy.

For a covered Dependent other than spouse: Illness or Disease.

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

1. It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided;
2. Its services are provided for compensation and under the full-time supervision of a Physician;
3. It provides 24-hour-per-day nursing services by licensed nurses, under the direction of a full-time registered nurse;
4. It maintains a complete medical record on each patient;
5. It has an effective utilization review plan;
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial Care or educational care or care of Mental Disorders; and
7. It is approved and licensed by Medicare.

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

Specialty Drug(s) shall mean high-cost prescription medications used to treat complex, chronic conditions including, but not limited to, cancer, rheumatoid arthritis and multiple sclerosis. Specialty Drugs often require special handling (like refrigeration during shipping) and administration (such as injection or infusion). Please contact the Prescription Drug Plan Administrator to determine specific drug coverage.

Substance Abuse and/or Substance Use Disorder shall mean any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.

The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.

Substance Abuse Treatment Center shall mean an Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;
2. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
3. Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

Surgery shall in the Plan Administrator's discretion mean the treatment of Injuries or disorders of the body by incision or manipulation, especially with instruments designed specifically for that purpose, and the performance of generally accepted operative and cutting procedures, performed within the scope of the Provider's license.

Surgical Procedure shall have the same meaning set forth in the definition of Surgery

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

Total Disability (Totally Disabled) shall mean in the case of a Dependent Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Uniformed Services shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

Urgent Care Facility shall mean a category of walk-in clinic, licensed as such under applicable law.

USERRA shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

Usual and Customary (U&C) shall mean Covered Charges which are identified by the Plan Administrator, taking into consideration any or all of the following:

1. The fee(s) which the Provider most frequently accepts for the majority of patients for the service or supply;
2. The cost to the Provider for providing the services;

3. The prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply; and/or
4. The Medicare reimbursement rates.

The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is Incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

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

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

Master charge list prices are not considered Usual and Customary.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ARTICLE XVII
PLAN ADMINISTRATION

The Plan Administrator has been granted the authority to administer the Plan. The Plan Administrator has retained the services of the Claims Administrator to provide certain claims processing and other technical services. The claims processing and other technical services delegated to the Claims Administrator notwithstanding, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

17.01 Plan Administrator

The Plan is administered by the Plan Administrator, and in accordance with these provisions. An individual, committee, or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the appointed Plan Administrator or a committee member resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

The Plan shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Covered Person is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

17.02 Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Covered Person's rights and/or availability of benefits;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a Claims Administrator to pay claims;
9. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO;
10. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate;

11. To approve, in its sole discretion, payment of, or reimbursement for, Covered Charges rendered by a Provider which has agreed to a charge for its services that are less than, or equal to, the charges that would otherwise be paid by the Plan; provided, reimbursement to a Covered Person for a Provider that accepts only cash payments from the Covered Person, shall be subject to the applicable Deductibles, Copayments or out-of-pocket requirements of the Plan;
12. To negotiate or approve contracts with specific Providers as the Plan Administrator deems is in the best interest of the Plan; including payment of a different amount payable under the Plan, taking into consideration specific circumstances;
13. To adjust, settle, contest, compromise and arbitrate any claims, debts or damages due and owing to or from the Plan, and to sue, commence or defend any legal proceedings in reference thereto. If the Plan Administrator considers it in the best interest of the Plan, they may abstain from enforcing any right, obligation or claim, or abandon any property held by the Plan;
14. To impose limitations of benefits and/or Providers as the Plan Administrator deem necessary or appropriate to ensure the fiscal viability of the Plan; provided, such limitations shall be applied in a uniform and consistent manner to all persons in similar circumstances; and
15. To perform each and every function necessary for or related to the Plan's administration.

17.02A Discretionary Authority

The Plan is administered by the Plan Administrator (which may be the Plan Sponsor or another entity appointed by the Plan Sponsor for this purpose), in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Plan Administrator (or the PACE insofar as it relates to Final Post-Service Appeals) shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

The Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, reserves the right to allocate certain discretionary authority as it applies to assessment and final determinative authority on and regarding Final Post-Service Appeal[s], to the "PACE."

The PACE's fiduciary duties extend only to those determinations actually made by the PACE, and with which the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan complies. An entity that may perform services as the PACE may perform other tasks on behalf of and in consultation with the Plan Administrator and/or Plan Sponsor, but not as the PACE, and the PACE shall only be deemed to be a fiduciary when making final determinations regarding plan coverage and claims examined via Final Post-Service Appeal. The Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan, is prohibited from referring to the PACE, in accordance with applicable law and/or pre-existing contract, in all other matters, including but not limited to, other appeals that are "not" Final Post Service Appeals.

The PACE shall at all times strictly abide by and make determination(s) in accordance with the terms of the Plan and applicable law. In instances where the Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, delegates fiduciary authority to the PACE to make a determination regarding a Final Post-Service Appeal, the PACE shall have discretion to interpret the terms of this Plan, and the PACE possesses all duties and rights otherwise ascribed to the Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, in this limited scope only. In such instances, the PACE's determinations will be final and binding on all interested parties, and failure to comply with said determination by the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan, shall absolve the PACE of any and all fiduciary (and other) liability, responsibility, obligations, and/or duties.

17.02B Duties and Rights of the PACE

When the PACE is assigned by the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan, the task of making a determination, regarding a Final Post-Service Appeal, the PACE shall possess the rights and exercise the duties otherwise ascribed to the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, only insofar as it relates to said Final Post-Service Appeals. Assignment is achieved by and when the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan advances a request for a Final Post-Service Appeal, received by the

Plan or its authorized agent(s), to the PACE with instructions to provide a directive regarding the Final Post-Service Appeal.

17.03 Amending and Terminating the Plan
This Plan was established for the exclusive benefit of the Employees with the intention it will continue indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the trust agreement (if any). All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Any amendment to the Plan that is not made effective at the beginning of a normal Plan Year by integration into a full Plan Document restatement, including suspension and/or termination, shall follow the amendment procedure outlined in this section. The amendment procedure is accomplished by a separate, written amendment decided upon and/or enacted by resolution of the Plan Sponsor's directors or officers (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or by the sole proprietor in his or her own discretion if the Plan Sponsor is a sole proprietorship, but always in accordance with applicable Federal and State law.

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for Covered Charges Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination.

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

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

17.05A Fiduciary Duties
A Fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s) and defraying Reasonable expenses of administering the Plan. These are duties which must be carried out:

1. With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
2. By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
3. In accordance with the Plan documents and applicable laws.

17.05B The Named Fiduciary
A "Named Fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. The named fiduciary has violated its stated duties under applicable laws in appointing the Fiduciary, establishing the procedures to appoint the Fiduciary or continuing either the appointment or the procedures; or
2. The named fiduciary breached its fiduciary responsibility under applicable laws.

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

ARTICLE XVIII
HIPAA PRIVACY

Commitment to Protecting Health Information
The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Covered Persons. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Covered Person's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The Covered Person's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Covered Person's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.

The Plan provides each Covered Person with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Covered Person's personal health information. It also describes certain rights the Covered Person has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling 1-830-778-4100.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in the Privacy Standards (45 CFR Sections 160.103 and 164.501). Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

How Health Information May Be Used and Disclosed
In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out payment of benefits.
2. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Covered Person's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.

2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Person's information.
3. Other Covered Entities: The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Covered Person has coverage through another carrier.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes
In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
6. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
7. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).
8. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

Required Disclosures of PHI

1. Disclosures to Covered Persons: The Plan is required to disclose to a Covered Person most of the PHI in a Designated Record Set when the Covered Person requests access to this information. The Plan will disclose a Covered Person's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Covered Person's personal representative if it has a reasonable belief that the Covered Person has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Covered Person's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Covered Person.

2. Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Covered Person's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Covered Person's Rights
The Covered Person has the following rights regarding PHI about him/her:

1. Request Restrictions: The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Covered Person has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and include how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Covered Person is entitled to receive a paper copy of the Plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.
4. Accounting of Disclosures: The Covered Person has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Person is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Covered Person of the basis of the disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Privacy Officer.
5. Access: The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Covered Person wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Covered Person and the recipient must be clearly identified. The Plan must respond to the Covered Person's request within 30 days (in some cases, the Plan can request a 30-day extension). In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial.
6. Amendment: The Covered Person has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. The request should be submitted to the Privacy Officer. The Plan may deny the Covered Person's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.
7. Other uses and disclosures not described in this section can only be made with authorization from the Covered Person. The Covered Person may revoke this authorization at any time.

Questions or Complaints

If the Covered Person wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the contact information below. The Covered Person may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Covered Person with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Covered Person for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Privacy Officer Contact Information

San Felipe Del Rio Consolidated Independent School District
Employee Benefits Coordinator
315 Griner Street
Del Rio, TX 78840
Phone: 1-830-778-4100
Fax: 1-830-778-4954
Email/Website: rachel.garcia@sfdr-cisd.org

ARTICLE XIX
HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

1. **Electronic Protected Health Information (ePHI)**, as defined in Section 160.103 of the Security Standards (45 CFR 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
2. **Security Incidents**, as defined within Section 164.304 of the Security Standards (45 CFR 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations
To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration functions (as defined in 45 CFR 164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
3. Report to the Plan any security incident of which it becomes aware.
4. Establish safeguards for information, including security systems for data processing and storage.
5. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
6. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer.
        ii. Director of Employee Benefits.
        iii. Employee Benefits Department employees.
        iv. Information Technology Department.
    b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

Disclosure of Summary Health Information to the Plan Sponsor
The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Resolution of Noncompliance
In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Covered Person's PHI to the Secretary of the U.S. Department of Health and Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

APPENDIX A
NOTICE OF NONDISCRIMINATION (FOR COVERED ENTITIES SUBJECT TO ACA SECTION 1557)

San Felipe Del Rio Consolidated Independent School District complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. San Felipe Del Rio Consolidated Independent School District does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

San Felipe Del Rio Consolidated Independent School District:

- Provides free aids and services to people with disabilities to communicate effectively with the Plan, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages

If a Covered Person needs these services, he or she should contact the Employee Benefits Coordinator.

If a Covered Person believes that San Felipe Del Rio Consolidated Independent School District has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, he or she can file a grievance with: San Felipe Del Rio Consolidated School District, Employee Benefits Coordinator for San Felipe Del Rios CISD, 315 Griner Street, Del Rio, TX 78840, 1-830-778-4100, 1-830-778-4976, sandrat.hernandez@sfdr-cisd.org. The Covered Person can file a grievance in person or by mail, fax, or email. If a Covered Person needs help filing a grievance, the Employee Benefits Coordinator is available to help him or her.

Covered Persons can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, dispone de servicios gratuitos de asistencia lingüística. Llame al 1-800-324-9396.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-324-9396

PAŽNJA: ako govorite bosanski, dostupne su vam usluge besplatne jezične pomoći. Nazovite 1-800-324-9396.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1–800–324–9396。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-324-9396.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-324-9396

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-324-9396.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-324-9396 पर कॉल करें।

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-324-9396 まで、お電話にてご連絡ください。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-324-9396 번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-324-9396.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-324-9396.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-324-9396

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-324-9396.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-324-9396.