Perrysburg Schools

Plan Document and Summary Plan Description for the Perrysburg School District Health and Welfare Benefit Plan

PPO PLAN A

Medical and Prescription Drug Benefits

Effective Date: 01/01/2020

Introduction

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

This booklet describes your medical and prescription drug benefits and serves as the Summary Plan Description (SPD) and Plan document for the Perrysburg School District Health and Welfare Benefit Plan ("the Plan").

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

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

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

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Plan Overview

Your Eligibility

You are eligible for benefits if you are:

- A full-time active employee normally scheduled to work a minimum of 30 hours per week;
- On the regular payroll of the Company; and
- In a class of employees eligible for coverage.

Unless otherwise communicated to you in writing by the Company, the following individuals are not eligible for benefits: part-time employees, employees of a temporary or staffing firm, payroll agency or leasing organization, persons hired on a seasonal or temporary basis, independent contractors and other individuals who are not on the Company payroll, as determined by the Company, without regard to any court or agency decision determining common-law employment status.

Eligible Dependents

You may enroll your eligible dependents on your coverage. Your eligible dependents include:

- your legal spouse;
- your child under age 26 regardless of financial dependency, residency with you, marital status, or student status;
- your unmarried child of any age who is principally supported by you and who is not capable of self-support due to a physical or mental disability that began while the child was covered by the Plan; or
- your unmarried child of any age who is not capable of self-support due to a physical or mental disability that occurred before age 26, whose disability is continuous, and who is principally supported by you.

“Principally supported by you” means that the child is dependent on you for more than one-half of his or her support, as defined by Code Section 152 of the Internal Revenue Code.

For purposes of the Plan, your child includes:

- your biological child;
- your legally adopted child (including any child lawfully placed for adoption with you);
- your stepchild;
- a foster child who has been placed with you by an authorized placement agency or by judgment decree or other court order;
- a grandchild for whom you are in a parent-child relationship who resides with you;
- a child for whom you are the court-appointed legal guardian;
- an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

An eligible dependent does not include a person enrolled as an employee under the Plan or any person who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the Company, each of you may elect your own coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the other's coverage, but only one of you may cover your dependent children.

It is your responsibility to notify the Company if your dependent becomes ineligible for coverage.

Proof of Dependent Eligibility

The Employer reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan. If you are asked to verify a dependent's eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled.

When Coverage Begins

For You

Your health care coverage begins on the first day of his or her first full month of Board employment.

If your employment with the Company terminates and you are later rehired or if you return from a leave of absence, special rules apply to determine when you will be eligible for the Plan's health care benefits. In general, under these rules, if you go at least 13 consecutive weeks without working for the Company and you then return, you will be treated as a new employee. Other rules may apply in different situations (for example, if you work for an educational organization or if the Company uses a rule of parity, different rules may apply). If you are treated as a continuing employee, the coverage and rules that would have applied to you if you had not experienced the break in service will apply upon your return. These rules are complex. For more specific information on your eligibility for coverage, contact the Plan Administrator.

For Your Dependents

Coverage for your eligible dependents begins on the same day as your initial eligibility provided you timely enroll your dependents in coverage.

If you acquire a new dependent through marriage, birth, adoption or placement for adoption, you can add your new dependent to your coverage as long as you enroll the dependent within 31 days of the date on which they became eligible. If you wait longer than 31 days, you may be required to wait until the Plan's next open enrollment period to enroll your new dependent for coverage.

A newborn child will be automatically covered by the Plan while the birth mother is hospital-confined. Coverage will continue only if you enroll him or her on your coverage within 31 days of birth. If you wait longer than 31 days after the date of birth, you may not be able to enroll your newborn child until the next annual open enrollment period.

Charges for nursery or physician care will be initially applied toward the plan of the covered parent. If the newborn child is not enrolled in the Plan on a timely basis, the covered parent will be responsible for all costs.

Your Cost for Coverage

Both the Company and you share in the cost of your health care benefits. Each year, the Company will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Your enrollment materials will show the coverage categories available to you.

You pay your portion of this cost through pre-tax payroll deductions taken from your pay each pay period. Your actual cost is determined by the coverage you select and the number of dependents you cover. You must elect coverage for yourself in order to cover your eligible dependents.

Enrolling for Coverage

New Hire Enrollment

As a newly eligible employee, you will receive enrollment information when you first become eligible for benefits. To enroll in medical and/or prescription drug coverage, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Company to deduct any required premiums from your pay.

The elections you make will remain in effect until the next December 31, unless you have a qualifying change in status. After your initial enrollment, you will enroll during the designated annual open enrollment period. If you do not enroll for coverage when initially eligible, you will only be eligible for the default coverages designated by the Plan Administrator, as shown in your enrollment materials.

Late Entrant

Your enrollment will be considered timely if your completed enrollment form is received within 31 days after you become eligible for coverage. You will be considered a “late entrant” if:

- You elect coverage more than 31 days after you first become eligible
- You again elect coverage after canceling

Unless the Special Enrollment Rights (see below) apply, if you are a late entrant, you will be required to wait until the next open enrollment period (but no longer than 12 months) to enroll in coverage.

Annual Open Enrollment

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your open enrollment materials will provide the options available to you and your share of the premium cost, as well as any default coverage you will be deemed to have elected if you do not make an election by the specified deadline. The elections you make will take effect on the following January 1 and stay in effect through December 31, unless you have a qualifying change in status.

Effect of Section 125 Tax Regulations on this Plan

It is intended that this Plan meets the requirements of the Internal Revenue Code Section 125 and the regulations thereunder and that the qualified benefits which you may elect are eligible for exclusion from income. The Plan is designed and administered in accordance with those regulations. This enables you to pay your share of the cost for coverage on a pre-tax basis. Neither the Company nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each annual open enrollment. However, at any time throughout the year, you can make changes to your coverage within 31 days following:

- The date you have a qualifying change in status as described below;
- The date you meet the Special Enrollment Rights criteria described below.

Qualifying Change in Status

If you experience a change in certain family or employment circumstances that results in you or a covered dependent gaining or losing eligibility under a health plan, you can change your coverage to fit your new situation without waiting for the next annual open enrollment period.

As defined by the Internal Revenue Service (IRS), status changes applicable to health care coverage include:

- your marriage;
- the birth, adoption, or placement for adoption of a child;
- your death or the death of your spouse or other eligible dependent;
- your divorce, annulment, or legal separation;
- a change in a dependent child’s eligibility due to age or eligibility for other coverage;
- a change in employment status for you or your spouse that affects benefits (including termination or commencement of employment, strike or lockout, or commencement of or return from an unpaid leave of absence);
- a reduction or loss of your or a dependent’s coverage under this or another plan;
- a court order, such as a QMCSO or NMSN, that mandates coverage for an eligible dependent child;
- change in employment status to less than 30 hours of service per week on average even if reduction does not result in loss of Plan eligibility;

If you experience a change in certain family or employment circumstances, you can change your coverage. Changes must be consistent with status changes as described above. For example, if you get married, you may change your coverage level from you only to you and your spouse. If you move, and your current coverage is no longer available in the new area, you may change your coverage option.

You should report a status change as soon as possible, but no later than 31 days, after the event occurs.

Keep in mind that certain mid-year election change events do not apply to health Flexible Spending Accounts (FSAs), such as cost or coverage changes. Contact the Plan Administrator if you have questions about when you can change your elections.

Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because you have other health coverage, you may be able to enroll yourself and your dependents in this Plan, if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

You or an affected eligible dependent may also enroll in coverage if eligibility for coverage is lost under Medicaid or the Children's Health Insurance Program (CHIP), or if you become eligible for premium assistance under Medicaid or CHIP. You must enroll under this Plan within 60 days of the date you lose coverage or become eligible for premium assistance.

This "special enrollment right" exists even if you previously declined coverage under the Plan. You will need to provide documentation of the change. Contact the Plan Administrator to determine what information you will need to provide.

When Coverage Ends

Your coverage under this Plan ends on the last day of the month in which your employment terminates or you cease to be an eligible employee unless benefits are extended as described below.

Coverage for your covered dependents ends when your coverage ends or, if earlier, on the date your dependent is no longer eligible for coverage under the Plan. Dependents will be terminated from the policy the date of their 26th birthday.

Coverage will also end for you and your covered dependents as of the date the Company terminates this Plan or, if earlier, the effective date you request termination of coverage for you and your covered dependents.

If your coverage under the Plan ends for reasons other than the Company's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) as described below.

Cancellation of Coverage

If you fail to pay any required premium for coverage under the Plan, coverage for you and your covered dependents will be canceled and no claims incurred after the effective date of cancellation will be paid.

Rescission of Coverage

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent performs an act, practice or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. A rescission of coverage is an adverse benefit determination that you may dispute under the

Plan's claims and appeals procedures. If your coverage is being rescinded due to fraud or intentional misrepresentation of material fact, you will receive at least 30 days' advance written notice of the rescission. This notice will outline your appeal rights under the Plan. Benefits under the Plan that qualify as "excepted benefits" under HIPAA are not subject to these restrictions on when coverage may be rescinded. Some types of retroactive terminations of coverage are permissible even when fraud or intentional misrepresentation are not involved. Coverage may be retroactively terminated for failure to timely pay required premiums or contributions as required by the Plan.

Also, coverage may be retroactively terminated to the date of your divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered dependent.

The Plan reserves the right to recover from you and/or your covered dependents any benefits paid as a result of the wrongful activity that are in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you and your covered dependents.

Coverage While Not at Work

In certain situations, health care coverage may continue for you and your dependents when you are not at work, so long as you continue to pay your share of the cost. If you are not receiving your pay during an absence, you will need to make arrangements for payment of any required premiums. You should discuss with your supervisor what options are available for paying your share of costs while you are absent from work.

If You are Totally Disabled

If you become totally disabled, your health care coverage may continue for up to 3 months, concurrent with any leave that is designated as FMLA, as long as you continue to pay your share of the cost or unless a separate agreement has been executed between the employee and employer.

If You Are Temporarily Laid Off

If you are laid off for a temporary period of time, your health care coverage will continue through the end of the month in which your layoff begins.

If You Take a Leave of Absence – FMLA

If you take an approved FMLA leave, your coverage will continue for the duration of your FMLA leave, as long as you continue to pay your share of the cost as required under the Company's FMLA Policy.

If You Take a Leave of Absence – Non-FMLA

If you take an approved leave of absence (paid or unpaid), your coverage will continue during your leave for up to 3 months, provided you continue to pay your share of the cost.

If You Take a Military Leave of Absence

If you are absent from work due to an approved military leave, health care coverage may continue for up to 24 months under both the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and COBRA, which run concurrently, starting on the date your military service begins.

Your Medical Benefits

Your medical benefits are delivered through a network of participating doctors, hospitals, laboratories, home health care agencies, and other health care providers, who have agreed to provide services at a discounted cost.

Benefits are provided through a Preferred Provider Organization, or “PPO”.

The Plan does not require you to select a primary care physician to coordinate your care and you do not have to obtain a referral to see a specialist.

A network of providers gives you the flexibility to choose providers inside or outside the network each time you need care. In most cases, the Plan covers the same medical services whether you receive care in- or out-of-network. Refer to the Summary of Medical Benefits chart below for more information.

To select a PCP, or to obtain a listing of current providers (at no cost to you) or confirm whether a provider participates in the network, contact the Claims Administrator.

If you use in-network providers, the Plan pays a higher percentage of covered expenses (after you meet any applicable deductible). Generally, you will not be required to file a claim form when you receive in-network benefits but in some cases, the provider or claims administrator may require you to do so. Please visit www.frontpathcoalition.com to obtain a list of participating providers.

If you receive professional services for anesthesiology, radiology, emergency room physician services, or pathology which are provided by an out-of-network provider but rendered at in-network facility, those services will be paid at the in-network level of benefits.

If you use out-of-network providers, the Plan pays a lower percentage of covered expenses (after you meet any applicable deductible), up to the reasonable and customary limit or maximum plan allowance (see explanation below). You are responsible for charges in excess of this limit and this excess amount may not apply to your deductible or any out-of-pocket maximum. You may also pay a higher deductible and out-of-pocket maximum (if applicable) out-of-network, and you may be required to file claim forms. See the Summary of Medical Benefits chart below for additional information.

Your Deductible

A deductible is money you must pay for certain covered expenses before the Plan pays benefits. It is calculated on a calendar year basis.

Consult the Summary of Medical Benefits chart for more information. Your medical deductible does not include:

- co-payments
- amounts in excess of the maximum amount payable under the Plan
- any expenses not covered under the Plan.

Deductible Accumulation

Each individual must meet the individual deductible before benefits are payable unless the family deductible is satisfied by one or more individuals, which will then satisfy the family deductible.

Charges applied to the out-of-network deductible will not be used to satisfy the in-network deductible amount and vice-versa.

Your Co-payment

Some services may require a co-payment – a fixed dollar amount you must pay before the Plan pays for that service. Copayments may apply regardless of whether the deductible has been satisfied. Please refer to the Summary of Medical Benefits chart for any required copayments and if the deductible may need satisfied before copayments are applied.

Your Coinsurance

Once you meet your deductible, the Plan pays a portion, or percentage, of certain covered medical expenses, and you are responsible to pay a portion. The percentage you must pay is called your coinsurance. For most services, the Plan will pay a higher percentage of the cost when you receive care in-network, which means your percentage will be lower.

The amount or percentage you pay depends on the type of provider you see, where you receive services, and how you are billed for these services. The Summary of Medical Benefits chart below shows the coinsurance levels for common medical services in-network and out-of-network.

Out-of-Pocket Maximum

The out-of-pocket maximum limits the total portion of costs you must pay in annual medical deductibles, coinsurance and copayments. It is calculated on a calendar year basis. When your share of eligible out-of-pocket medical expenses reaches the out-of-pocket maximum, your coinsurance percentage and copayments become zero for the rest of the year – and the Plan pays 100% of covered expenses. See the Summary of Medical Benefits chart below for the out-of-pocket maximum amounts.

The following expenses do not apply toward your out-of-pocket maximum:

- amounts in excess of the maximum amount payable under the Plan
- any expenses not covered under the Plan.

Out-of-Pocket Accumulation

A family's combined expenses must meet the family out-of-pocket maximum before covered expenses are payable at 100% for any covered family member for the year. However, if a covered family member satisfies the plan's individual out-of-pocket maximum, his or her covered expenses will be payable at 100% for the year.

The separate individual out-of-pocket maximum for individuals with family coverage only applies to in-network benefits. A family's combined expenses must meet the family out-of-pocket maximum before out-of-network expenses are payable at 100% for any covered family member for the year.

Your spending for covered out-of-network expenses does not count toward the in-network out-of-pocket maximum. Likewise, your spending for covered in-network expenses does not count toward the out-of-pocket maximum for out-of-network services.

Maximum Allowed Amount (Reasonable/Usual and Customary Limits)

If you use out-of-network providers, covered medical expenses are subject to certain limits under the Plan, and you are responsible for paying any charges above this limit. The maximum benefit payable is based on the amount determined by the Plan to be the prevailing charge for a covered service or supply. Determination of the prevailing charge is based on the:

- complexity of the service and level of specialty of the provider;
- range of services provided; and
- the geographic area where the provider is located and other geographic areas with similar medical cost experience.

Summary of Medical Benefits

	In-Network	Out-of-Network
Annual Deductible (applies to expenses below unless otherwise noted)	$300 / individual $600 / family	$600 / individual $1,200 / family
Annual Out-of-Pocket Maximum (includes deductible and coinsurance)	$900 / individual $1,800 / family	$1,800 / individual $3,600 / family
Annual Out-of-Pocket Maximum (includes deductible, coinsurance, copayments, and RX)	$7,900 / individual $15,800 / family	$7,900 / individual $15,800 / family

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Allergy Testing, Serum, and Treatment (Deductible does not apply In-Network)	Plan pays 100% (after $25 co-payment)	Plan pays 70%
Allergy Shots (Deductible does not apply In-Network)	Plan pays 100%	Plan pays 70%
Ambulance Service	Plan pays 90%	Plan pays 70% (emergency services paid at in-network level when a true emergency)
Ambulatory Surgical Center	Plan pays 90%	Plan pays 70%

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Anesthetics, Oxygen, Transfusions	Plan pays 90%	Plan pays 70%
Chemotherapy (Deductible does not apply In-Ne	Plan pays 90%	Plan pays 70%
Chiropractic Care	Plan pays 90%	Plan pays 70%
Diagnostic X-rays and Lab Services		
Performed in and billed by a physician's office (Deductible does not apply In-Network)	Plan pays 100% (after applicable office visit co-payment)	Plan pays 70%
Performed in and billed by an outside lab/facility	Plan pays 90%	Plan pays 70%
Pre-admission Testing (performed prior to a hospital confinement) (Deductible does not apply In-Network)	Plan pays 100%	Plan pays 70%
Advanced Radiological Imaging (requires precertification)	Plan pays 90%	Plan pays 70%
Durable Medical Equipment (Equipment must be prescribed by a physician. Wigs are covered to a limit of $500)	Plan pays 90%	Plan pays 70%
Emergency/Acute Care Hospital ER Room (copayment waived if admitted)	Plan pays 100% (after $100 co-payment)	Plan pays 100% (after $100 co-payment) (emergency services paid at in-network level when a true emergency)
Acute Care Facility	Plan pays 90%	Plan pays 70%
Hemodialysis	Plan pays 90%	Plan pays 70%
Home Health Care (4 hours or less of non-custodial Home Health Aide Service = 1 visit)	Plan pays 90%	Plan pays 70%

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Hospice Care	Plan pays 90%	Plan pays 70%
Hospital Services – Inpatient Requires precertification – see also Pregnancy below.	Plan pays 90%	Plan pays 70%
Hospital Services – Outpatient	Plan pays 90%	Plan pays 70%
Infertility Treatment (includes services for the diagnosis of infertility only)	Plan pays 90%	Plan pays 70%
Maternity Benefits – includes physician services for prenatal visits and routine pre- and post-partum care, childbirth and pregnancy-related conditions		
Inpatient hospital services or birthing center including labor and delivery (requires precertification for extended stay only)	Plan pays 90%	Plan pays 70%
Medical Supplies	Plan pays 90%	Plan pays 70%
Mental Health and Substance Abuse Treatment		
Doctor's office visits or Outpatient/Intermediate Care	Plan pays 100% (deductible waived)	Plan pays 70%
Inpatient Care (requires precertification)	Plan pays 90%	Plan pays 70%
Newborn Care – Inpatient	Plan pays 90%	Plan pays 70%
Organ Transplants – See description of coverage and limitations below Precertification required.	Plan pays 90%	Plan pays 70%
Private Duty Nursing	Plan pays 90%	Plan pays 70%

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Primary Care Physician - Office visit for injury or sickness (excludes preventive care, surgery and other medical services and supplies) (Deductible does not apply In-Network)	Plan pays 100% (after $25 co-payment)	Plan pays 70%
Specialist Physician – Office visit for injury or sickness (excludes preventive care, surgery and other medical services and supplies) (Deductible does not apply In-Network)	Plan pays 100% (after $25 co-payment)	Plan pays 70%
Prosthetics	Plan pays 90%	Plan pays 70%
Radiation Therapy	Plan pays 100% (Deductible is waived)	Plan pays 70%
Routine Preventive Care/Wellness Benefits (Deductible does not apply In-Network)		
Routine periodic and screening exams	Plan pays 100%	Plan pays 70%
Women's Preventive Services	Plan pays 100%	Plan pays 70%
Well-baby/Well-child Care	Plan pays 100%	Plan pays 70%
Immunizations	Plan pays 100%	Plan pays 70%
Routine Patient Costs relating to Approved Clinical Trials	Plan pays 90%	Plan pays 70%
Second Surgical Opinions – voluntary (Deductible does not apply In-Network)	Plan pays 100% (after $25 co-payment)	Plan pays 70%
Skilled Nursing Facility Precertification required.	Plan pays 90%	Plan pays 70%

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Sterilization Procedures	Plan pays 90%	Plan pays 70%
Surgery		
Hospital Inpatient (requires precertification)	Plan pays 90%	Plan pays 70%
Outpatient Facility	Plan pays 90%	Plan pays 70%
Therapy Services *Occupational Therapy* *Pulmonary/Respiratory Therapy* *Speech Therapy*		
Performed in and billed by Physician's office	Plan pays 90%	Plan pays 70%
Performed at outpatient facility or inpatient	Plan pays 90%	Plan pays 70%
Physical Therapy	Plan pays 90%	Plan pays 70%
Cardiac Rehabilitation	Plan pays 90%	Plan pays 70%

** A Primary Care Physician or PCP may be a family practitioner, general practitioner, internist, gynecologist, or pediatrician. A Specialist may be a physician or other health care provider other than a PCP, for example, a cardiologist, allergist, gynecologist, chiropractor, or physical therapist. The final designation will depend on how the provider has chosen to contract with the network.*

Eligible Expenses

Eligible expenses are for services and supplies that are approved by a physician or other approved provider and must be medically necessary for the care and treatment of a covered sickness, accidental injury, pregnancy or other covered health care condition. Services received from an out-of-network provider are subject to the Reasonable and Customary limit (see above).

The following are common conditions and services for which expenses are typically paid:

- **Abortion** – includes charges for non-elective abortions.
- **Ambulance** – includes medically necessary professional ambulance services. A charge for this item will be a covered charge only if the service is to the nearest hospital or skilled nursing facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was medically necessary. Includes charges

for local ground or air transportation by a professional ambulance service. Emergency ambulance services will be paid at the in-network provider level of benefits.

- **Ambulatory Surgical Center** – includes services and supplies provided by an Ambulatory Surgical Center in connection with a covered outpatient surgery. A Center is a licensed facility used mainly for performing outpatient surgery and does not provide for overnight stays.
- **Amniocentesis** – see Pregnancy
- **Anesthesia** – includes anesthetics and the services of a licensed physician or certified nurse anesthetist (C.R.N.A.)
- **Birthing Center** – includes services and supplies provided by a licensed Birthing Center in connection with a covered pregnancy.
- **Blood** – includes blood and blood derivatives (if not replaced by or on behalf of the patient), including blood processing and administration services.
- **Cardiac Rehabilitation** – see Therapy, Short-Term
- **Chemical Dependency** – see Substance Abuse
- **Chemotherapy** – includes medically necessary and appropriate drugs and services of a physician or medical provider; also includes initial purchase of a wig following chemotherapy.
- **Circumcision**
- **Clinical Trials** – This plan will cover Routine Patient Costs for a Qualified Individual participating in an Approved Clinical Trial that is conducted in connection with the prevention, detection or treatment of cancer or other life-threatening disease or condition and is federally funded through a variety of entities or departments of the federal government, is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration, or is exempt from investigational new drug application requirements.
- **Counseling** – includes counseling services by a licensed or approved provider for: diabetes and nutritional education;
- **Diagnostic Lab and X-Ray, Outpatient** – includes laboratory, X-ray, EKGs, and other non-surgical services performed to diagnose medical disorders by physicians throughout the United States; advanced scanning and imaging work (e.g., CT scans, MRIs) and other similar advanced tests
- **Emergency Room Visits** – includes medical treatment for an emergency. An emergency is an accident or the sudden and unexpected onset of an acute condition, illness, or severe symptoms that require immediate medical care. Examples include fractures, lacerations, motor vehicle accidents, hemorrhage, shock, poisoning, or other conditions associated with deterioration of vital life functions.

  Colds, sore throats, flu, and infections are examples of nonemergencies, although they may require urgent treatment.

  The Plan does not cover non-emergency care received in an emergency room.
- **Genetic Testing** – (also see Pregnancy) in accordance with the Genetic Information Nondiscrimination Act of 2008, the Plan will not discriminate against any participant on the basis of genetic information. This includes any information obtained for an

individual from genetic tests, genetic tests of family members, and the manifestation of a disease or disorder in family members.

- **Hemodialysis Services** – includes the services of a person to assist the patient with home dialysis, when provided by a hospital, freestanding dialysis center or other approved covered provider.
- **Hospital Services** – include hospital charges for the following:
    - Room and board - For a semiprivate room, charges are covered at the most common rate; for a private room in a hospital with semiprivate rooms, charges are covered only up to the hospital's most common semiprivate room rate. However, if it is medically necessary to stay in a private room, the full charge will be a covered medical expense. For a private room in a private-room-only hospital, the full cost of the private room will be considered a covered medical expense.
    - services required for medical or surgical care, whether as an outpatient or inpatient, and other related services;
    - services of nursing staff and other hospital staff providing care;
    - emergency room services; and
    - medically necessary services.

  An inpatient hospital stay for the diagnosis of a sickness or injury will be covered only if the stay is mandatory or is required for the safety of the patient or the success of a medical treatment or test. Also includes services that can be done on an outpatient basis, or services performed inpatient when a concurrent medical hazard exists that prevents the patient from being treated on an outpatient basis.
- **Medical Supplies** – includes supplies such as casts, splints, dressings, catheters, colostomy bags, oxygen and syringes and needles for the treatment of allergies or diabetes.
- **Medicines** – includes medicines dispensed and administered during an inpatient stay. See Prescription Drug Benefits for outpatient prescription drug coverage information.
- **Mental Health** – coverage for mental health treatments are treated the same as benefits provided for other medical conditions in accordance with the Mental Health Parity and Addiction Equity Act of 2008.
- **Midwife** – includes services of a certified or registered nurse midwife when provided in conjunction with a covered pregnancy.
- **Newborn Care** – includes services and supplies for a covered newborn who is sick or injured, including infant formula when needed for the treatment of inborn errors of metabolism while the infant is hospital-confined. Also includes hospital nursery services and routine newborn care provided during the birth confinement or on an outpatient basis for non-hospital births.

  Services for a newborn child are covered only if the child is enrolled in coverage within 31 days of birth.
- **Obesity** - Surgical treatment of morbid obesity will be covered if the Participant meets ALL of the following criteria:

  a. The patient has had a diagnosis of morbid obesity for at least five years;

b. The patient has a body maximum index (BMI) greater than or equal to 40 or a BMI greater than 35 with any of the following severe co-morbidities:

(1) Coronary heart disease;

(2) Type 2 diabetes mellitus;

(3) Hypertension; or

(4) Sleep apnea;

c. The patient is between the ages of 18 and 55;

d. The patient has been on a medically supervised weight loss and exercise program for 6 consecutive months prior to the surgery date, and occurring within three years of the proposed surgery date. Medical supervision must occur under an M.D., D.O., N.P., or R.D. To review the medical necessity of the obesity surgery, all of the following documentation must be submitted for review:

(1) Description of the supervised dietary program;

(2) Patient response to dietary program;

(3) Documentation of the patient participating in an exercise program;

e. Evaluation by a licensed psychologist or psychiatrist documenting the absence of significant psychopathology that can limit a patient's ability to comply with the pre- and post-operative regimen; and

f. Documentation that the patient is willing to comply with all pre- and postoperative treatment plans.

Experimental and Investigational procedures are not covered by the Plan. These procedures may include but are not limited to:

a. Loop gastric bypass

b. Gastroplasty (stomach stapling)

c. Duodenal switch operation

d. Biliopancreatic bypass (Scopinaro procedure)

e. Mini gastric bypass

The Plan also excludes any reduction or removal of excess skin as a result of weight reduction (e.g. liposuction, panniculectomy, thigh/breast/arm reduction, etc.), regardless of the condition of the skin;

- **Occupational Therapy** – see Therapy, Short-Term
- **Organ and Tissue Transplants** – If you or a covered dependent faces a potential transplant, contact the Plan as soon as possible to determine the benefits available to you.

  Transplant benefits are provided under a separate transplant program and will include the services of a transplant coordinator to assist you. Arrangements will be made at a facility approved by the Plan. Covered transplant services include room and board, physician's fees, and other related services.

Benefits include charges incurred for the care and treatment related to an approved transplant. This benefit includes expenses for the original procedure and any follow-up visits that occur within three years of the original procedure. No transportation charges will be covered.

Transplants are limited to one transplant per participant per calendar year.

If the transplant recipient is covered by the Plan, benefits will be provided only when the hospital and physician customarily charge a recipient for such care and services. No benefits will be payable for services for which a participant would not be legally obligated to pay if there were no coverage under the Plan.

Expenses incurred by a live donor are not covered.

Expenses in connection with any type of artificial or mechanical organ or replacement are not covered by the Plan.

Other: The Plan provides no benefits for:
a. Expenses related to the donor's transportation, whether or not the donor is a Participant;
b. Transplants involving artificial organ or tissues;
c. The purchase price of any bone marrow, organ, or tissue that is sold rather than donated;
d. Any expenses in connection with any transplant procedure which is not in accordance with generally accepted professional medical standards, or for an Experimental or Investigative procedure which has not been proven successful and effective;
e. Any transplant procedure (recipient or donor) performed under a study, grant or research program;
f. Treatment, services, and supplies not ordered by a Physician or surgeon;
g. Human-to-human bone marrow, organ, or tissue transplants other than those specifically covered under this section;
h. Treatment, services, and supplies not covered by the Plan..

- **Podiatry** – includes treatment for bunions (when an open cutting operation is performed); or any required medically necessary surgical procedure on the foot. Excludes coverage for routine foot care or treatment of unstable or flat feet.
- **Preventive Care Services**

  Covers routine preventive care services as defined by the United States Preventive Services Task Force (USPSTF) A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, (CDC), and Health Resources and Services Administration (HRSA) Guidelines including the American Academy of Pediatrics Bright Futures periodicity guidelines. Additional preventive care and screenings for women are covered as defined by the Health and Human Services Health Plan Coverage Guidelines for Women's Preventive Services.

  Coverage includes but is not limited to:

  - routine physicals, which include medical history, physical exam, prostate exam, colonoscopy, weight/height, blood pressure, cholesterol screening, urinalysis, blood glucose, and EKG, as medically appropriate;
  - routine gynecological exam and Pap smear;
  - routine mammogram;

- well baby/well child care; and
- immunizations.

- **Private Duty Nursing.** Services of a practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.) when ordered by a Physician will be covered as follows: Nursing services do not include care that is primarily non-medical or custodial in nature such as bathing, exercising and feeding. Benefits are not provided for a nurse who usually lives in your home or is a member of your immediate family;
- **Prosthetics** – includes the initial purchase of artificial limbs, eyes or other prosthetic appliances required to replace natural limbs, eyes or other body parts which have been lost due to an accidental injury, sickness or surgery. Also includes replacement of a prosthetic device due to a change in the patient's physical condition that makes the original device no longer functional.

  To comply with the Women's Health and Cancer Rights Act, coverage includes post-mastectomy breast prostheses.
- **Radiation Therapy** – includes radium and radioactive isotope therapy.
- **Reconstructive Surgery** – includes reconstructive surgery after a mastectomy, including reconstructive surgery of the breast on which the mastectomy was performed as well as reconstructive surgery of the other breast to produce a symmetrical appearance is also covered in accordance with the Women's Health and Cancer Rights Act of 1998. Coverage includes prostheses and treatment of physical complications in all stages of the mastectomy, including lymphedemas.

  Coverage also includes charges for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; also includes surgery required to repair a congenital absence or agenesis (lack of formation or development) of a body part. Excludes coverage for abnormalities of the jaw or conditions related to TMJ disorder.
- **Respiratory/Pulmonary Therapy** – see Therapy, Short-Term
- **Second Surgical Opinions** – covers a second surgical opinion you voluntarily obtain before recommended surgery. Second opinions provide you with more information so that you can make an informed decision about whether to have surgery or follow another course of treatment.
- **Skilled Nursing/Sub-Acute Facility** – includes room and board and non-custodial nursing care provided under the treatment plan of a physician if the patient is confined as a patient in the facility. and must be for the same condition for which the patient was hospitalized.
- **Sleep Disorders** – includes services, supplies, medications, and testing related to the diagnosis and treatment of sleep disorders, such as insomnia, narcolepsy, sleep apnea, and parasomnias. Excludes sleep therapy treatments designed to modify behaviors or sleep habits.
- **Speech Therapy** – see Therapy, Short-Term
- **Sterilization** – includes voluntary sterilization procedures for employee and covered spouse only. Excludes reverse sterilization procedures.
- **Substance Abuse** – includes inpatient, partial hospitalization, and outpatient treatment of substance abuse, as well as intensive outpatient programs if approved

by the Plan. For Plan purposes, "substance abuse" is physical and/or emotional dependence on drugs, narcotics, alcohol or other addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine.

- **Surgery** – includes surgeries performed in a doctor's office, outpatient facility or hospital. However, payments for multiple surgical procedures or surgeries involving more than one surgeon or assistant will be paid based on the primary procedure and the number of procedures and individuals involved. Payments for assistant surgeons may be limited as well. Any procedure not integral to the primary procedure or unrelated to the diagnosis will not be covered.

  If multiple surgeries are performed at the same time by one surgeon, the eligible covered expense is the fee for the major procedure plus 25 percent of the R&C charge for additional procedures performed through the same incision.

- **Therapy, Short-Term** – includes the following rehabilitation therapy services provided on an outpatient basis:
    - Cardiac Rehabilitation Therapy – includes services provided under the supervision of a physician in an approved facility in connection with a myocardial infarction, coronary occlusion, or coronary bypass surgery, in order to restore physiological and psychological well-being to an individual with heart disease. Must be initiated within 12 weeks after other treatment for the medical condition ends.
    - Physical Therapy – Includes services by a licensed therapist or physician for improvement of bodily function and provided in accordance with physician's order as to type, frequency and duration.
    - Occupational Therapy - includes services and supplies when provided by a certified occupational therapist under the direction of a physician that are needed to improve and maintain a patient's ability to function;
    - Pulmonary/Respiratory Therapy – includes services of a licensed respiratory or inhalation therapist, when prescribed by a physician as to type and duration for function improvement of chronic respiratory impairment;
    - Speech Therapy – Includes services of a licensed speech therapist when prescribed by a physician following surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy), injury, or sickness ;

  Maintenance care is not covered under any category above.

- **TMJ / Jaw Joint Treatment** – charges for appliances for the treatment of, or in connection with, temporomandibular joint disorders. Surgical services are not covered

For More Information

If you have a question about a covered service, or for more information about a specific procedure or service described above, contact the Claims Administrator.

Expenses Not Covered

The following expenses, among others, are not covered under the Plan:

Alternative Treatments

- music therapy;
- massage therapy;
- charges for pain disorder services or treatment including, but not limited to biofeedback, aversion therapy, self-help programs, services rendered by a masseur/masseuse, health club membership fees, or any similar type program designed for pain disorders such as ultrasound-guided extracorporal shock wave therapy;
- acupuncture or acupressure treatments unless administered by a licensed physician;

Comfort/Convenience Items and Services

- custodial care/assistance with activities of daily living, whether in a residential care facility, skilled nursing facility, or at home, including help in walking, bathing, preparing meals and special diets, and supervising use of medication;
- personal convenience items or equipment including, but not limited to, radio/television rentals, air conditioners, humidifiers, air purification or heating units, exercise equipment, elastic bandages or stockings, non-hospital adjustable beds, orthopedic mattresses, blood pressure instruments, scales, and first aid supplies and other non-prescription drugs or medicines;

Dental/Oral

- diagnostic and treatment services related to jaw joint problems including temporomandibular joint syndrome (TMJ);
- orthodontic treatments;
- charges for dental care provided by an active dental plan;
- routine dental care, except for services to correct damage to sound natural teeth due to an accident that happens while a person is covered under the Plan and as described above under eligible expenses;

Podiatry/Foot Care

- Charges for examinations or fittings for routine care and treatment;

Medical Supplies/Appliances

- replacement braces unless there is sufficient change in the patient's condition to make the original device no longer functional;
- mechanical or artificial organ transplants or implants (except Intraocular Lens Implants);

Counseling

- services of dieticians and/or nutritionists and nutrition programs (except for Diabetes Education);
- educational or vocational testing;
- ancillary services for learning disabilities or developmental delays;

Physical Appearance

- services, supplies, or treatment primarily for weight reduction or treatment of obesity, including but not limited to gastrointestinal surgery, hormones, medications, exercise programs or use of exercise equipment, special diets or supplements, appetite suppressants, weight loss programs, and hospital confinements for weight reduction programs.
- services for cosmetic reasons, except for covered reconstructive surgery;
- expenses related to the care and treatment of hair loss (excluding wigs after chemotherapy if indicated under eligible expenses above);
- services, supplies or treatment of weight reduction (except for morbidly obese as described above)

Reproduction/Sexual

- services, supplies, or treatment for transsexualism, gender dysphoria, or sexual assignment or change, including medications, implants, hormone therapy, surgery, or medical or psychiatric treatment;
- treatment of benign gynecomastia;
- sterilization reversals;

- fertility treatments such as in-vitro fertilization, GIFT, fertility assistance, and other artificial insemination or impregnation procedures;
- fertility treatments (except as provided under Eligible expenses above);
- diagnosis, care, or treatment of sexual dysfunction or impotence, including expenses for supplies or services for the restoration or enhancement of sexual activity not related to organic disease (except as may be covered under the Prescription Drug benefit);
- genetic testing;

Services Provided by Another Plan

- services and supplies covered by laws or regulations of any government agency, unless specifically covered under the Plan;
- services for any condition, illness, or injury, or complication thereof arising out of or in the course of employment, when the participant or covered dependent is furnished care or services covered hereunder, or could or might have been furnished such care and services if pursued or sought, according to the provisions of any Worker's Compensation or occupational disease law, or any other law or regulation of the United States, or of a state, territory or subdivision thereof, or under any policy of Worker's Compensation or occupational disease insurance, or according to any recognized legal remedy available to the participant or covered dependent;

Travel-Related Expenses

- travel and accommodation expenses unless provided above under the Plan for a particular service;
- expenses for care or treatment outside of the United States if travel was for the

sole purpose of obtaining medical services;

Hospital/Hospice Services

- any hospital stay that is not for the diagnosis or treatment of a sickness or injury;
- non-emergency hospital admissions on a Friday or Saturday unless surgery is performed within 24 hours of admission;
- complications resulting from non-covered services (other than abortion);

Home Services/Nursing

- home management and compensatory training, meal preparation, safety procedures, and adaptive equipment instructions used to support activities of daily living;
- respite care;
- outpatient private duty nursing;

Vision/Hearing

- routine eye exams, eyeglasses, contact lenses, or related services, except the initial eyeglasses or contact lenses after a cataract operation or the special contacts necessary to treat keratoconus; this exclusion does not apply to aphakic patients and soft lenses or sclera shells for use as corneal bandages;
- expenses for radial keratotomy or any other surgery to correct nearsightedness or refractive errors;

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;

Behavioral Exclusions

- services to treat injuries sustained or a sickness contracted while the participant or covered dependent committed or attempted to commit a felony or misdemeanor, or was engaged in an illegal occupation or activity, assault, or felonious behavior or activity; this exclusion does not apply to an injury or sickness contracted as the result of domestic violence or a medical (both physical or mental) condition;
- services or expenses to treat an intentionally self-inflicted injury while sane or insane; this exclusion does not apply if the injury resulted from an act of domestic violence or a medical (both physical or mental) condition;
- services, supplies, care, or treatment for an injury or sickness that results from engaging in a hazardous hobby or activity. A hobby or activity is hazardous if it is characterized by a constant threat of danger or risk of bodily harm such as (but not limited to) skydiving, auto or powerboat racing, hang gliding, jet ski operating, rock climbing, or bungee or base jumping;
- services, supplies, care or treatment resulting from a participant's or covered dependent's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for injured participants other than the person using controlled substances and

expenses will be covered for substance abuse treatment as provided by the Plan (does not apply if the injury resulted from an act of domestic violence or a medical (physical and mental health) condition);

- services, supplies, care or treatment resulting from a participant's voluntary taking or being under the influence of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a physician. Expenses will be covered for injured participants other than the person using controlled substances and expenses will be covered for substance abuse treatment as provided by the Plan (does not apply if the injury resulted from an act of domestic violence or a medical (physical and mental health) condition;
- services to treat injuries sustained or a sickness contracted while the participant or covered dependent committed or attempted to commit a serious illegal act which includes any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or if filed, that a conviction results, or that a sentence for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required (does not apply if the injury resulted from an act of domestic violence or a medical (physical or mental health) condition);
- charges for failure to keep a scheduled visit, telephone consultations between patient and doctor, or completion of claim forms;
- services, supplies, care, or treatment for an injury or sickness which occurred as the result of or was caused by engaging in an illegal act or occupation; by committing or attempting to commit a crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance (does apply if the injury resulted from an act of domestic violence or a medical (physical or mental health) condition);
- smoking cessation programs (except as may be provided under eligible expenses);
- sleep disorders (except as may be provided under eligible expenses);

All Other

- expenses resulting from complications of a treatment not covered by the Plan (other than abortion);
- services rendered by an unlicensed provider;
- services or supplies for sickness, defect, disease, or injury due to war or a warlike action in time of peace;
- services and supplies that are experimental or investigational, except as provided for under eligible expenses;
- services or supplies that are not medically necessary for diagnosing or treating your condition, as determined by the Plan;
- any charges in excess of the maximum amount payable under the Plan for a particular service or supply (see "Maximum Allowed Amount" above);
- autopsies;

- services or supplies received before the patient is covered by the Plan;
- services or supplies for which the patient does not have to pay, or for which no charges would be made if this coverage did not exist;
- services not recommended and approved by a physician or treatment, services, or supplies when the participant is not under the regular care of a physician that is appropriate care for the injury or sickness;
- services performed by a person who ordinarily resides in the participant's home or who is related to the participant and/or his covered dependents as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Precertification

You and your covered dependents are required to obtain precertification for inpatient hospitalization (and certain other treatments) as shown in the Summary of Medical Benefits above. In some cases, the in-network provider may obtain the precertification for you; however, to ensure that you receive the maximum benefit, you should verify that the request was submitted to the Plan.

To receive the maximum benefit and avoid any penalty for failure to precertify, you must call the number listed listed below to precertify an admission or treatment:

- at least 2 weeks prior to any scheduled or non-emergency hospital admission or treatment;
- within 48 hours of an emergency or unscheduled admission. Your case will be reviewed by the Plan to determine how many days of treatment are medically necessary.

Precertification - Pregnancy and Childbirth

Precertification will not be required for an inpatient admission for pregnancy delivery that does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.

Penalty for Noncompliance with Precertification

If precertification requirements are not met, any covered expenses incurred may not be covered.

The precertification coordinator will work with your physician to determine the appropriate length of stay for your condition. If an extension is required for your hospital confinement, you (or a family member or your attending physician) must obtain approval for the extension before the original approved stay expires. If an extension is approved, you, your attending physician, and the hospital will receive written notification of the approval. If the criteria for an extended stay are not met, your stay will be denied and you may file an appeal of the denial through the Plan's appeal process.

Case Management

Through the case management program, you receive appropriate health care services for serious or catastrophic medical conditions. The Plan Administrator may arrange for review

and/or case management from a professional who is qualified to perform such services. The Plan Administrator has the right to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost-effective result without sacrificing the quality of patient care. The case management program may provide benefits or alternative care not otherwise routinely available through the Plan under special circumstances.

While many diagnoses may require special attention, the Plan may use case management for conditions such as, but not limited to:

- Acquired Immune Deficiency Syndrome (AIDS);
- burns;
- coma;
- inpatient confinement expected to exceed 14 days;
- multiple sclerosis/Amyotrophic Lateral Sclerosis (Lou Gehrig's disease);
- neonatal birth;
- organ transplant;
- progressive neurological debilitative disease;
- certain psychiatric conditions;
- quadriplegic/paraplegic conditions;
- stroke; and
- multiple traumas from a vehicular accident.

Benefits provided under the program are subject to all other Plan provisions. Alternative treatments will be determined on the merits of each individual case and will not be considered as setting any precedent or creating any future liability with respect to any participant. Case management will be involved for in-network services that meet the established criteria.

Your Prescription Drug Benefits

How the Plan Works

If you elect medical coverage under the Plan, you are automatically enrolled in the Prescription Drug program. Your Plan helps pay the cost of covered prescription drugs that are medically necessary for treatment of a sickness or injury. Covered drugs must be:

- prescribed by a licensed physician or dentist and dispensed by a registered pharmacist; and
- approved by the United States Food and Drug Administration (FDA) for general use in treating the illness or injury for which they are prescribed.

Managed Pharmacy Network

Prescription drug benefits are provided through a managed pharmacy network.

You may purchase covered prescription drugs at any participating network retail pharmacy.

Coverage Categories and Your Co-payment

There are three tiers in the prescription drug Plan; each has a different co-payment that applies depending on where you have your prescription filled. The chart below shows your co-payment amounts, co-payment maximum out-of-pocket amounts, and any deductible. If your Plan has a deductible, you must satisfy the deductible before the Plan pays benefits.

Prescription Drug Tiers

Level 1 – Generic Drug: Using generic drugs when available, instead of costlier brand-name drugs, can save you money. Pharmacies will dispense generic equivalent drugs, which are therapeutically equivalent to their brand-name drug in safety and effectiveness, when taken as prescribed unless your physician orders a specific brand name drug. The co-payment for generic drugs is $5 per prescription for up to a 30-day supply. For generic drugs purchased through the mail service program, the co-payment is $5 per prescription for up to a 90-day supply.

Level 2 – Preferred or Formulary Brand Name Drugs: This category includes brand-name drugs for which there are no or limited generic drug alternatives. Most brand-name drugs used to treat asthma or diabetes are included in this category. If a generic drug is available, it will automatically be dispensed unless your physician orders a brand name drug or you request it. If you request brand-name when a generic drug is available, you will pay the difference between the generic and brand name drug and no limits will apply, if applicable. Your co-payment for formulary (brand-name) drugs at a network retail pharmacy is $20 per prescription for up to a 30-day supply. For formulary drugs purchased through the mail service program, the co-payment is $20 per prescription for up to a 90-day supply.

Level 3 – Non-Preferred or Non-Formulary Brand Name Drugs: This category includes brand-name drugs for which no generic equivalent drugs and/or appropriate generic drug alternatives are available. Your co-payment for non-formulary drugs at a network retail pharmacy is $35 per prescription for up to a 30-day supply. For non-formulary drugs purchased through the mail service program, the co-payment is $35 per prescription for up to a 90-day supply.

Using a Network Retail Pharmacy

The retail pharmacy network includes most chain and many local pharmacies. There are no claim forms to complete when you use a network retail pharmacy.

If You Use an Out-of-Network Retail Pharmacy

Coverage for prescriptions purchased at out of network pharmacies are not covered under this plan.

Mail-Service Program

The mail-service program is a cost-effective and convenient way to purchase up to a 90-day supply of covered medication through the mail. The mail-service program is used for maintenance prescription drugs, such as blood pressure medication, taken on a regular or long-term basis. It also can be used for any medication that is not needed immediately. Non-formulary drugs are not eligible to be filled through the mail service program.

To fill a prescription through the mail-service program, you must complete an order form and include your co-payment (using a credit card, check, or money order). With your first order, you also must include the original prescription order written by your doctor and a completed patient profile form.

Your filled prescription will be mailed directly to your home. Your order will include a preprinted envelope and a notice with instructions on how to request a refill prescription; you will not need a new prescription from your doctor if the prescription is still valid. Refills can also be conveniently refilled by phone or by using Pharmacy Manager's Web site www.express-scripts.com.

Your Prescription Drug Coverage

	In-Network Retail Pharmacy (up to a 30-day supply)	Mail-Service Program (up to a 90-day supply)
	Co-Pay	Co-Pay
Generic	$5	$5
Preferred Brand Name	$20	$20
Non-Preferred Brand Name	$35	$35

Prior Authorization and Limits

Certain prescriptions may require prior authorization by the Claims Administrator. This process allows the Plan to verify that the drug is a part of a specific treatment plan and is medically necessary. Your physician will need to contact the Claims Administrator with written documentation of the reason for prescribing the medication and the length of time it should be covered. If you discover that a prescription requires prior authorization while you are at a retail pharmacy, you or the pharmacist will need to contact your doctor, who must then contact the Claims Administrator.

If your prescription is authorized by the Plan, you will be able to fill your prescription at any participating pharmacy or through the mail service program. If authorization is not received, you will be required to pay the full cost of the prescription.

Certain drugs may also be limited by drug-specific quantity limitations per month, benefit period, or lifetime as specified by the Plan and based on medical necessity. Other drugs may be covered under your medical benefits and will be subject to your deductible and coinsurance. If your prescription is affected by these limits, you or your pharmacist should contact the Claims Administrator.

Covered Prescription Drugs and Supplies

The following prescription drugs and supplies, among others, are covered under the Plan:

- Alcohol swabs, when needed for injectable medicines;
- Hypodermic and insulin syringes and needles for administering injectable drugs if prescribed by a doctor and purchased with the drug as part of the same order;
- Diabetic supplies (such as Chemstrips);
- Insulin, disposable insulin pens, insulin cartridges, and pen needles (non-disposable insulin pens are considered medical supplies and are covered under medical benefits);
- Adapalene (Differin);
- Pigmenting and depigmenting agents;
- Drugs to treat narcolepsy including Provigil;
- Attention Deficit Disorder (ADD) drugs (e.g., Adderall, Dexedrine, Ritalin);
- Vitamins and dietary supplements that require a prescription;
- Oral contraceptives, injectable contraceptives, and contraceptive devices (e.g., IUDs and diaphragms);
- All dosage forms of smoking-cessation aids, whether prescription type (such as Wellbutrin), or physician-prescribed over-the-counter type (such as nicotine patches and nicotine gum);
- AZT, Retrovir, and other drugs used for the purpose of treating HIV/AIDS, unless considered experimental or investigational.

Expenses Not Covered

The following drugs and supplies, among others, are not covered under the Plan:

- Any prescription refilled in excess of the number specified by the doctor, or any refill dispensed more than one year after the doctor’s original order;
- Drugs or supplies covered under Workers’ Compensation or occupational disease law or any similar law;
- Drugs labeled “Caution—limited by Federal law to investigational use,” or experimental drugs, even though a charge is made to the individual;
- Drugs and medicines that may not be prescribed within the scope of the doctor’s license;
- Medication administered in a doctor’s office or health care facility (other than contraceptive-related medications);
- Prescriptions filled in hospital out-of-network pharmacies at time of discharge;

- Therapeutic devices or appliances, support garments, and other non-medicinal substances, regardless of intended use;
- Fertility drugs;
- Anti-Wrinkling Agents (e.g., Renova);
- Drugs used to treat or cure baldness or hair loss (e.g., Minoxidil);
- Drugs for weight loss;
- Immunization agents or biological sera;
- Injectable Supplies (other than for Insulin);
- Drugs used for treatments that are cosmetic-related;
- Over-the-counter drugs and products unless specifically listed as covered expenses in the plan.

For More Information

If you have a question about a covered prescription or supply, or for more information about a specific drug or service described above, contact the Claims Administrator.

Medicare Part D Creditable Coverage

If you are Medicare-eligible, you should be aware that Medicare offers prescription drug coverage (known as Medicare Part D). You are not required to choose this coverage. The Plan will continue to provide your prescription drug coverage if you become eligible for Medicare. If you enroll in coverage under this Plan and under Medicare Part D, you will be paying more for additional insurance that you may not need as Medicare Part D will not supplement your coverage under this Plan. There is no coordination between the plans.

Prescription drug coverage under this Plan is, on average, at least as good as Medicare prescription drug coverage; therefore, there is no advantage to signing up for Medicare Part D coverage. The government refers to this as “creditable coverage”. Since the Plan’s coverage is considered to be creditable, you will not be subject to penalties or restrictions if you later choose to enroll in a Medicare prescription drug plan.

Administrative Information

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- how to contact the Plan Administrator;
- how to contact the Claims Administrators;
- what to do if a benefit claim is denied; and
- your rights under ERISA and other Federal laws such as COBRA.

Plan Sponsor and Administrator

Perrysburg School District is the Plan Sponsor for this Plan. You may contact the Plan Administrator at the following address and telephone number:

International Benefits Administrators, LLC
SUITE 110
Garden City, NY 11530
878-222-4410

As set forth in Section 3(16) under ERISA, the Plan Administrator will administer this Plan and will be the “Named Fiduciary” for the Plan. The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Company. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the Company, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;
- To maintain and preserve appropriate Plan records; and
- To accept all other responsibilities and duties of the administrator of the Plan as specifically set forth in ERISA.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Plan Year

The Plan Year is January 1 through December 31.

Type of Plan

This Plan is called a “welfare plan”, which includes group health plans under ERISA; they help protect you against financial loss in case of sickness or injury.

Identification Numbers

The Employer Identification Number (EIN) and Plan number for the Plan is:

EIN: 34-6401068 PLAN NUMBER: 501

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows.

Type of Administration	Benefits are self-funded and are administered through contracts with third-party administrators.
Funding	The Company and employees both contribute to the Plan. The Company will use these contributions to pay benefits to or on behalf of Plan Participants from the Company’s general assets. Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using Company contributions to pay for the cost of such benefit.

Claims Administrators

The Plan Administrator has contracted with the following company(ies) to administer benefits and pay claims. You may contact the appropriate Claims Administrator directly, using the information listed below.

The Plan Administrator has also contracted with different third-party administrators, to handle certain day-to-day administrative functions such as utilization review, provider contracting and prescription benefit management for the Plan. While these service providers make every attempt to provide accurate information, mistakes can occur. It is important to understand that Federal law requires that the Plan documents always control, even if their terms conflict with information given to you by a service provider.

Medical

Claims Administrator

International Benefits Administrators, LLC
SUITE 110
Garden City, NY 11530
878-222-4410
www.ibatpa.com

Prescription Drug Administrator

Express Scripts, Inc.
One Express Way
Saint Louis, MO 63121
800-824-0898
www.express-scripts.com

COBRA Administrator

Benefit Strategies
P.O. Box 1300
Manchester, NH 03105
888-401-3539
www.benstrat.com

Utilization Review/Case Management

Administrator

American Health Holding
866-790-4177

Agent for Service of Legal Process

If any disputes arise under the Plan, papers may be served upon:

Perrysburg School District
140 East Indiana Avenue
Perrysburg, OH 43551
419-874-9131

Service of legal process also can be made upon the Plan Administrator.

No Obligation to Continue Employment

The Plan does not create an obligation for the Company to continue your employment or interfere with the Company's right to terminate your employment, with or without cause.

Non-Alienation of Benefits

With the exception of a Qualified Medical Child Support Order, your right to any benefit under this Plan cannot be sold, assigned, transferred, pledged or garnished. The Plan Administrator has procedures for determining whether an order qualifies as a QMCSO; participants or beneficiaries may obtain a copy without charge by contacting the Plan Administrator.

Severability

If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

Payment of Benefits

All benefits are payable when the Plan Administrator receives written proof of loss. Benefits will be payable to the covered participant, unless otherwise assigned. If you receive care from a non-network provider, it is your responsibility to pay the non-network provider for the charges you incurred, including any difference between what you were billed and what the Plan paid. You may not assign your benefits under the Plan to a non-network provider without the Company's consent. The Company (or a Claims Administrator) reserves the right, in its discretion, to pay a non-network provider directly for services rendered to you. Direct payment to a non-network provider shall not be deemed to constitute consent by the Company or waive the consent requirement for assigning benefits.

Payment of Benefits to Others

The Plan Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Expenses

All expenses incurred in connection with the administration of the Plan, are Plan expenses and will be paid from the general assets of the Company.

Fraud

No payments under the Plan will be made if the participant or the provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Plan Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. Any employee or his or her covered dependent who attempts or commits fraud upon the Plan may have their coverage terminated and may be subject to disciplinary action by the Company, up to and including termination of employment.

Indemnity

To the full extent permitted by law, the Company will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative ("Plan Administration Employee") of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.

Compliance with Federal Mandates

The Plan is designed to comply to the extent possible with the requirement of all applicable laws, including but not limited to: ERISA, COBRA, USERRA, HIPAA, the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), WHCRA, FMLA, the Mental Health Parity and Addiction Equity Act of 2008, PPACA, HITECH, Michelle's Law, and Title I of GINA.

Non-discrimination

In accordance with IRC Section 125, the Plan is intended not to discriminate in favor of Key Employees (as defined in Code Section 416) or Highly Compensated Individuals as to eligibility to participate; or in favor of Highly Compensated Participants as to contributions and benefits, nor to provide more statutory nontaxable benefits than permitted under applicable law to Key Employees. The Plan Administrator will take such actions necessary to ensure that the Plan does not discriminate in favor of Key Employees, Highly Compensated Individuals, or Highly Compensated Participants.

Future of the Plan

The Company expects that the Plan will continue indefinitely. However, the Company has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The Company may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.

Claims Procedures

This section describes what you must do to file or appeal a claim for services received in- and out-of-network.

In-Network Claims — Generally, no claim forms are necessary when you use in-network (participating) providers. Benefits for in-network covered services always are paid to the provider. If you pay the provider for a covered service, you must contact the provider to request a refund.

Out-of-Network Claims — If you use out-of-network (non-participating) providers, you might need to pay them when you receive services, including any coinsurance amount. You must then submit a claim form along with an itemized bill to the appropriate Claims Administrator. In most cases, the Claims Administrator will reimburse you directly. Occasionally, however, the Claims Administrator may reimburse the provider directly for covered expenses. If this happens to you and you already have paid your provider, you must request a refund from your provider.

The steps described below will guide you through the process of submitting your out-of-network claim. To obtain a form, contact your Claims Administrator. Complete a separate claim form for each covered family member who has expenses. If you already paid all or a portion of the fee to the provider, indicate the amount paid on the claim form.

For medical expenses, your Claims Administrator will send you an Explanation of Benefits (EOB) showing what the Plan covered. You may receive a bill from the provider for the remainder of the expense, which will be your responsibility to pay. Send the completed claim form to the appropriate Claims Administrator along with any proof of payment (i.e., a receipt).

To be eligible for reimbursement under the Plan, a claim must be submitted within the time frames established by the Plan Administrator. Claims filed after that time may be reduced or denied. If you are unable to file a claim within the prescribed time frame, the Plan Administrator may elect to approve the claim after reviewing any extenuating circumstances if the claim is filed as soon as possible.

Time Frames for Processing a Claim

Through your employer Perrysburg School District and your administrator International Benefits Administrators, LLC mandates that claims must be filed within 365 days (12 months) of the date of service. Failure to file a claim within this time frame can result in denial of claim processing.

Claims are divided into urgent care claims, concurrent care claims, pre-service health claims, and post-service health claims. If you or your representative fail to follow the Plan's procedures for filing a claim or if you file an incomplete claim, the Plan will notify you or your representative of the failure according to the time frames shown in the following chart.

If an initial claim is denied in whole or in part, you or your representative will receive written notice from the Plan Administrator. This notice will include the reasons for denial, the specific Plan provision involved, an explanation of how claims are reviewed, the procedure for requesting a review of the denied claim, a description of any additional material or information that must be submitted with the appeal, and an explanation of why it is necessary. If your claim for benefits is denied, you or your representative may file a written appeal for review of a denied claim with the Plan Administrator.

The chart below shows the time frames for filing different types of claims with the Plan. If you have any questions about what type of claim you may have or the timing requirements that apply to your claim, please contact your Claims Administrator.

Time Frames for Processing a Claim				
Claim Process	**Urgent Care Claim**	**Concurrent Care Claim**	**Pre-Service Health Claim**	**Post-Service Health Claim**
Claims Administrator determines initial claim is improperly filed (not filed according to Plan procedures) or is not complete	Within 24 hours after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Within 24 hours after receipt of request for extension of urgent concurrent care	Within 5 days after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Not applicable
Claims Administrator determines that you must submit additional information required to complete claim	Within 48 hours after receipt of notice that your claim is incomplete	Not applicable	Within 45 days after receipt of notice that additional information is required	Within 45 days after receipt of notice that additional information is required
Claims Administrator reviews claim and makes determination of:		For urgent care claims, within 24 hours after receipt of the claim, provided request is submitted at least 24 hours prior to expiration of prescribed period of time or number of treatments. If not submitted within 24 hours prior to expiration of prescribed period of time or number of treatments, not later than 72 hours after receipt of claim.* For non-urgent care claims, determination will be made within time frame designated for type of claim (pre- or post-service) and prior to expiration of prescribed period of time or number of treatments.*		
complete/proper claim	Within 48 hours after the earlier of: receipt of requested information, or at end of period allowed for you to provide information		Within 15 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information	Within 30 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information
initial claim	Within 72 hours of receipt of initial claim		Within 15 days of date initial claim is received	Within 30 days of date initial claim is received
Extension period,** if required due to special circumstances beyond control of Claims Administrator	Not applicable	Not applicable	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 15-day period	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 30-day period

* A request for extension of treatment will be deemed to be an initial claim. A reduction or termination of approved, ongoing treatment will be deemed to be an adverse claim decision. If the Claims Administrator makes an adverse decision, you will be notified of the reduction/termination within a time frame that allows you to submit an appeal and have a determination on the appeal prior to the expiration of the prescribed period of time or number of treatments.

** Whenever an extension is required, the Plan must notify you before the current determination period expires. The notice must state the circumstances requiring the extension and the date a determination is expected to be made.

How to Appeal a Claim

To appeal a denied claim or to review administrative documents pertinent to the claim, you or your representative must send a written request to the Plan. You may also appeal the Plan's decision to rescind your coverage due to fraud or intentional misrepresentation of material fact. The time frames for appealing a claim are shown in the following chart.

If you or your representative submit an appeal, state why you think your claim should be reviewed and include any data, documents, questions, or comments, along with copies of itemized bills and claim forms relating to your claim. You may request, free-of-charge, copies of all documents, records, and other information relevant to your claim. A reviewer who did not make the initial claim determination will be responsible for reviewing your appeal. Also, you will be notified of any expert advice obtained on behalf of the Plan in reviewing the denied claim, regardless of whether such advice was relied upon in reviewing your claim. Such experts will not be individuals who were consulted in making the initial claim determination.

Time Frames for Appealing Denied Claims

Appeal Process	Urgent Care Claim	Concurrent Care Claim	Pre-Service Health Claim	Post-Service Health Claim
You may submit an appeal of denied initial claim to the Claims Administrator	Within 180 days of receiving notice of denied claim	You will be notified of reduction or termination of benefit in time to submit appeal and receive determination before benefit ends	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
Claims Administrator reviews your first appeal and makes determination	Within 72 hours after appeal is received	Prior to reduction or termination of benefit	Within 15 days of date appeal is received	Within 30 days of date appeal is received
You may submit a second appeal to the Plan Administrator	N/A	N/A	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
The Plan Administrator reviews your second appeal and makes final determination	N/A	N/A	Within 15 days of date appeal is received	Within 30 days of date appeal is received

You will be notified of the Plan Administrator's decision in writing. If your claim is denied, the Plan Administrator will give you in writing the specific reason(s) that your claim was denied, the specific reference to the Plan provisions on which the denial was based, any internal rules, guidelines, protocols, or similar criteria used as basis for the decision, a statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and a statement regarding your right to bring civil action in Federal court under Section 502(a) of ERISA.

The decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law.

Exhaustion Required

If you do not file a claim, follow the claims procedures, or appeal a claim within the timeframes permitted, you will give up all legal rights, including your right to file suit in

Federal court, as you will not have exhausted your internal administrative appeal rights. Participants or claimants must exhaust all remedies available to them under the Plan before bringing legal action. Additionally, legal action may not be brought against the Plan more than one year after a final decision on appeal has been reviewed under the Plan.

External Review Rights

If, after exhausting your internal appeals, you are not satisfied with the determination made by the Claims Administrator, you may be entitled to request an external review of the Claims Administrator’s decision. You will be notified in writing if your claim is eligible for an external review and you will be informed of the timeframes and the steps necessary to request an external review. In most cases, you must complete all levels of the internal claims and appeal procedure before you can request an external review.

External review is only available for adverse benefit determinations that involve medical judgment or a rescission of coverage.

If you decide to seek external review, an independent external review organization (an "IRO") will be assigned your claim. The IRO does not have to give deference to any earlier claims and appeals decisions, but it must observe the written terms of the Plan document. In other words, the IRO is not bound by any previous decision made on your claim. The ultimate decision of the IRO will be binding on you, the Claims Administrator and the Plan.

You or your representative may request a standard external review, or an expedited external review in urgent situations, by following the directions in the determination letter. A request for an external review must be made within four months after the date you received Claims Administrator's decision.

For additional information about the external IRO process, contact the Claims Administrator.

Coordination of Benefits

This section describes how benefits under this Plan are coordinated with other benefits to which you or a covered dependent might be entitled.

Non-Duplication of Benefits / Coordination of Benefits

If a Plan participant is covered by another employer's plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits.

Your medical benefits are coordinated with benefits from:

- other employers' plans;
- certain government plans; and
- motor vehicle plans when required by law.

Non-duplication of benefits does not apply to prescription drug benefits.

How Non-Duplication Works

When an expense is covered by two plans, the following apply:

- the primary plan is determined and pays the full amount it normally would pay;
- the secondary plan calculates the amount it normally would pay and then pays any portion of that amount not paid by the primary plan (but not to exceed 100% of charges); and
- you pay any remaining expenses.

If another plan is primary and this plan is secondary, the Plan will calculate the amount it would pay as if there were no other coverage, subtract the amount payable by the primary plan, and then pay any eligible remaining amount.

Determining Primary and Secondary Plans

Primary and secondary plans are determined as follows.

- A plan that does not contain a coordination of benefits provision is primary.
- If you are the employee, this Plan normally is primary when you have a covered expense.
- If your covered spouse is the patient, your spouse's company plan (if applicable) is primary. Your spouse should submit expenses to that plan first, wait for the payment, and then submit the claim under this Plan with copies of the expenses and the primary plan's Explanation of Benefits (EOB).
- When both parents' plans cover an eligible dependent child, the plan of the parent whose birthday (month and day) comes first in the calendar year is primary. For example, if your spouse's birthday is March 15 and your birthday is September 28, your spouse's plan is primary. If both parents were born on the same day, the plan of the parent who has had coverage in effect the longest will be primary. However, if the other plan does not have this birthday rule and, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.
- When parents who are legally separated or divorced both cover an eligible dependent child, the following rules apply.

- If the parents have joint custody and there is no court decree stating which parent is responsible for health care expenses, the birthday rule previously stated will apply.
- If one parent has custody, his or her plan is primary and the other parent's plan is secondary. If the parent with custody remarries, the stepparent's plan becomes secondary and will pay before the plan of the parent without custody (the third plan).
- If the remarried parent with custody has no health care coverage, the stepparent's plan is primary and the plan of the parent without custody is secondary.
- Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses and that parent has enrolled the child in his or her plan, that parent's plan is primary.
- When none of the previous rules applies, the plan that has covered the patient for the longer period is primary.

Coordination with Medicare

If you are actively employed after becoming eligible for Medicare, your coverage under the Plan will be coordinated with Medicare. Which plan pays first ("primary") is determined by whether your Employer is considered a small or large group employer. Generally, for large group employer plans, Medicare requires the employer's plan to pay first and Medicare pays second ("secondary"). You should check with your Employer if you become eligible for Medicare while employed to determine if your Employer's coverage will be primary or secondary.

The Plan also coordinates with Medicare as follows.

- End-stage renal disease—If you or a covered dependent is eligible for Medicare due to end-stage renal disease, this Plan will be primary for the first 30 months of dialysis treatment; after this period, this Plan will be secondary to Medicare for this disease only.
- Mandated coverage under another group plan—If a person is covered under another group plan and Federal law requires the other group plan to pay primary to Medicare, this Plan will be tertiary (third payer) to both the other plan and Medicare.

Coordination with Auto Insurance Plans

First-party auto insurance coverage is considered primary. This Plan coordinates its benefits with the first-party benefits from an auto insurance plan without regard to fault for the same covered expense.

If you or your covered dependent incurs covered expenses as a result of an automobile accident (either as driver, passenger, or pedestrian), the amount of covered expenses that the Plan will pay is limited to:

- any deductible under the automobile coverage;
- any co-payment under the automobile coverage;

- any expense properly denied by the automobile coverage that is a covered expense; and
- any expense that the Plan is required to pay by law.

For Maximum Benefit

Generally, claims should be filed promptly with all plans to receive the maximum allowable benefits. You must supply the claim information needed to administer coordination of benefits. If you receive more payment than you should when benefits are coordinated, you will be expected to repay any overpayment.

Subrogation and Reimbursement

If you or your dependent receives benefits in excess of the amount payable under the Plan, the Company has a right to subrogation and reimbursement, as defined in the following sections.

Right of Recovery

The Plan has the right to recover benefits it has paid on your or your dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period you were meeting the calendar year deductible; or
- advanced during the time period you were meeting the out-of-pocket maximum for the calendar year.

Benefits paid because you or your dependent misrepresented facts also are subject to recovery. If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested; or
- reduce a future benefit payment for you or your dependent by the amount of the overpayment.

Right to Subrogation

The right to subrogation means the Plan is substituted to any legal claims that you may be entitled to pursue for benefits that the Plan has paid. Subrogation applies when the Plan has paid benefits for a sickness or injury for which a third party is considered responsible (e.g., an insurance carrier if you are involved in an auto accident).

The Plan will be subrogated to, and will succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and benefits the Plan has paid on your behalf relating to any sickness or injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes a sickness or injury for which you receive a settlement, judgment, or other recovery, you must use those proceeds to return to the Plan 100 percent of any benefits you received for that sickness or injury.

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a sickness, injury, or damages, or who is legally responsible for the sickness, injury, or damages; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
    - underinsured or uninsured motorist insurance;
    - medical provisions of no-fault or traditional insurance (auto, homeowners, or otherwise);
    - Workers' Compensation coverage; or
    - any other insurance carrier or third party administrator.

When This Provision Applies To You

If you or any of your covered dependents, or anyone who receives benefits under this plan, becomes ill or is injured and is entitled to receive money from any source, including but not limited to any party's liability insurance or uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the Plan will be paid only if you fully cooperate with the terms and conditions of the Plan.

As a condition of receiving benefits under this Plan, you agree that acceptance of benefits for you and/or your dependents is constructive notice of this provision in its entirety and agree to reimburse the Plan 100 percent of any benefits provided or to be provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. You further agree that the Plan shall have an equitable lien on any funds received by you or your dependents, and/or you or your attorney, if any, from any source for any purpose and shall be held in trust until such time as the obligation under this provision is fully satisfied. If you or your dependent retains an attorney, then you and your dependents agree to only retain one who will not assert the Common Fund or Made-Whole Doctrines. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

You or your covered dependent agrees to sign any documents requested by the Plan including but not limited to a reimbursement and/or subrogation agreement, or accident questionnaire, as the Plan or its agent(s) may request. You and your covered dependent also agree to furnish any other information as may be requested by the Plan or its agent(s). Failure to sign and return any requested documentation or information may result in the Plan's denial of claims. However, such failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received, regardless of how characterized, shall first be deemed for reimbursement of expenses paid by the Plan. Any excess after 100 percent reimbursement to the Plan may be divided between you or your dependent (the covered person) and your attorney if applicable. Any accident-related claims made after satisfaction of this obligation shall be paid by you or your dependent and not the Plan.

You and/or your covered dependents agree to take no action which in any way prejudices the rights of the Plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against you or your dependent (the covered person), then you and/or your dependent agree to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

The Plan Administrator has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary. Furthermore, the Plan may reduce or deny any future benefits by the amount of any recovery received, but not reimbursed, by you or your covered dependent for an accident or injury for which the Plan paid benefits.

If you and/or your covered dependent take no action to recover money from any source, then you and/or your dependent agree to allow the Plan to initiate its own direct action for reimbursement.

Your Rights under ERISA

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

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), if applicable, and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the previously mentioned rights. For instance, if you request a copy of Plan documents (i.e., Summary Plan Descriptions and Summary of Material Modifications) or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the

control of the administrator. If, after you exhaust your appeals, you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. Such suit must be filed within 180 days from the date of an adverse appeal determination notice. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Assistance with Your Questions

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

Your HIPAA/COBRA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. These rules are called the HIPAA Privacy Rules.

You will receive a “Notice of Privacy Practices” from the Administrator(s) and/or Insurer(s) that contains information about how your individually identifiable health information is protected under the HIPAA Privacy Rules and who you should contact with questions or concerns.

The HIPAA Privacy Rules apply to group health plans. These plans are commonly referred to as “HIPAA Plans” and are administered to comply with the applicable provisions of HIPAA. PHI is individually identifiable information created or received by HIPAA Plans that relates to an individual’s physical or mental health or condition, the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper or oral. When PHI is in electronic form it is called “ePHI.”

The HIPAA Plans may disclose PHI to the Plan Sponsor only as permitted under the terms of the Plan, or as otherwise required or permitted by HIPAA. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by the HIPAA Privacy Rules and the terms of the Plan.

The HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose enrollment and disenrollment information to the Plan Sponsor. Also, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the information for the purposes of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending or terminating the Plan. “Summary Health Information” means information that summarizes the claims history, claims expenses or types of claims experienced by individuals covered under the HIPAA Plans and has almost all individually identifying information removed. The HIPAA Plans may also disclose PHI to the Plan Sponsor pursuant to a signed authorization that meets the requirements of the HIPAA Privacy Rules.

In addition, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose PHI to the Plan Sponsor for plan administration purposes. Plan administration purposes means administration functions performed by the Plan Sponsor on behalf of the HIPAA Plans, such as claims processing, coordination of benefits, quality assurance, auditing and monitoring. Plan administration purposes do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor or any employment-related actions or decisions.

The Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information, Summary Health Information and information disclosed pursuant to a valid HIPAA authorization) disclosed to it by the HIPAA Plans (or an Insurer with respect to the HIPAA Plans), the Plan Sponsor will:

- Not use or further disclose the information other than as permitted or required by the Plan or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides PHI received from the HIPAA Plans agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the HIPAA Plans any use or disclosure of PHI of which it becomes aware that is inconsistent with the permissible uses or disclosures;
- Make PHI available in accordance with the individual rights of access under the HIPAA Privacy Rules;
- Make an individual's PHI available for amendment, and incorporate any amendments, as required by the HIPAA Privacy Rules;
- Make available the information required to provide an accounting of disclosures to individuals, as required by the HIPAA Privacy Rules;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the HIPAA Plans available to the Secretary of the Department of Health and Human Services for purposes of determining compliance with HIPAA's requirements;
- If feasible, return or destroy all PHI received from the HIPAA Plans that the Plan Sponsor still maintains in any form and retain no copies of this information when no longer needed for the purpose for which disclosure was made, except that, if this return or destruction is not feasible, limit further uses or disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure adequate separation between the HIPAA Plans and the Plan Sponsor is established.

In addition, the Plan Sponsor will reasonably and appropriately safeguard ePHI (other than enrollment/disenrollment information, Summary Health Information and information disclosed pursuant to a valid HIPAA authorization) that is created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the HIPAA Plans. The Plan Sponsor will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the HIPAA Plans;
- Ensure that adequate separation between the HIPAA Plans and the Plan Sponsor is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the HIPAA Plans any security incident of which it becomes aware.

Continuing Health Care Coverage through COBRA

In special situations, you or your covered dependent(s) may continue health care coverage at your or your dependent's expense when it otherwise would end. The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows a continuation of health care coverage to qualified beneficiaries for a specific length of time. This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the "qualifying event." These events and the applicable COBRA continuation period are described below.

If you and/or your eligible dependent(s) choose COBRA coverage, the Company is required to offer the same medical and prescription drug coverage that is offered to similarly situated employees. Proof of insurability is not required to elect COBRA coverage. In other words, you and your covered dependents may continue the same health care coverage you had under the Plan before the COBRA qualifying event.

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 30 days of the child's birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 30 days, you will have to wait until the next open enrollment period to enroll your child.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

For more information about the Marketplace, visit www.HealthCare.gov.

COBRA Qualifying Events and Length of Coverage

Each person enrolled in benefits will have the right to elect to continue health benefits upon the occurrence of a qualifying event that would otherwise result in such person losing health benefits. Qualifying events and the length of COBRA continuation are as follows:

18-Month Continuation

Health care coverage for you and your eligible dependent(s) may continue for 18 months after the date of the qualifying event if your:

- employment ends for any reason other than gross misconduct; or
- hours of employment are reduced.

18-Month Continuation Plus 11-Month Extension

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of coverage in addition to

the 18-month continuation period (for a total of 29 months of coverage). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

The 11-month extension is available to any COBRA participant who meets all of the following requirements:

- he or she becomes disabled before or within the first 60 days of the initial 18-month coverage period; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) within 60 days of the date on the Social Security Administration determination letter, and provides a copy of the disability determination; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) before the initial 18-month COBRA coverage period ends.

You must also notify the Plan Administrator (or its designated COBRA Administrator) within 30 days of the date Social Security Administration determines that you or your dependent is no longer disabled.

36-Month Continuation

Coverage for your eligible dependent(s) may continue for up to 36 months if coverage is lost due to your:

- death;
- divorce or legal separation;
- eligibility for Medicare coverage; or
- dependent child's loss of eligible dependent status under this Plan

Note: If any of these events (other than Medicare entitlement) occur while your dependents are covered under COBRA (because of an 18-month or 18-month plus extension qualifying event), coverage for the second qualifying event may continue for up to a total of 36 months from the date of the first COBRA qualifying event. In no case, however, will COBRA coverage be continued for more than 36 months in total.

If you become eligible for Medicare before a reduction in hours or your employment terminates, coverage for your dependents may be continued for up to 18 months from the date of your reduction in hours or termination of employment, or for up to 36 months from the date you became covered by Medicare, whichever is longer.

COBRA Notifications

If you or your covered dependents lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you or your dependents with additional information about COBRA continuation coverage, including what actions you must take by specific deadlines.

If your covered dependent loses coverage as a result of your divorce, legal separation or a dependent child's loss of eligibility under the Plan, you or your dependent must notify the Company within 60 days of the qualifying event. The Plan Administrator (or its designated

COBRA administrator) will automatically send you or your dependent, as applicable, COBRA enrollment information. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. To continue COBRA coverage, you and/or your eligible dependents must elect and pay the required cost for COBRA coverage.

Cost of COBRA Coverage

You or your eligible dependent pays the full cost for health care coverage under COBRA, plus an administrative fee of two percent, or 102 percent of the full premium cost, except in the case of an 11-month disability extension where you must pay 150 percent of the full premium cost for coverage.

COBRA Continuation Coverage Payments

Each qualified beneficiary may make an independent coverage election. You must elect COBRA coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. Each month's premium is due prior to the first day of the month of coverage. You or your dependent is responsible for making timely payments.

If you or your dependent fails to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated. Other important information you need to know about the required COBRA coverage payments follows.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

You may be eligible for state or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your state insurance commissioner.

How Benefit Extensions Impact COBRA

If you have a qualifying event that could cause you to lose your coverage, the length of any benefit extension period is generally considered part of your COBRA continuation coverage period and runs concurrently with your COBRA coverage. (Also see "Coverage While You Are Not at Work" in the Plan Overview for additional information.)

If you take a leave under the Family and Medical Leave Act (FMLA), COBRA begins;

- at the end of the leave if you do not return after the leave; or
- on the date of termination if you decide to terminate your employment during the leave.

When COBRA Coverage Ends

COBRA coverage for a covered individual will end when any of the following occur:

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group medical plan.
- The individual becomes entitled to Medicare.
- The Company terminates its group health plan coverage for all employees.
- Social Security determines that an individual is no longer disabled during the 11-month extension period.

Definitions

Accident

An unexpected or reasonably unforeseen occurrence or event that is definite as to time and place.

Actively at Work

A participant is considered actively at work if he or she:

- is presently at work on a scheduled workday performing the regular duties of his or her job for the hours he or she is normally scheduled to work; or
- was present at work on the last scheduled working day before:
    - a scheduled vacation;
    - an absence due to a paid holiday, paid jury or witness day, or a paid bereavement day;
    - a scheduled day off within the participant's working schedule; or
    - an absence excused by the Company.

Approved Clinical Trial

A phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection or treatment of cancer or other life-threatening disease or condition and is federally funded through a variety of entities or departments of the federal government, is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration, or is exempt from investigational new drug application requirements.

Birthing Center

A facility that provides prenatal, labor, delivery, and postpartum care for medically uncomplicated pregnancies.

Centers of Excellence

Centers of Excellence are medical centers/hospitals throughout the country that frequently perform highly specialized medical care and achieve the highest success rates in patient outcomes and care. They are selected on the basis of quality indicators, such as survival rates and morbidity, as well as cost efficiencies (based on national average costs for similar procedures). Typically, the procedures performed by these Centers include heart, lung, liver, pancreas-kidney, and bone marrow transplants.

Certified Nurse-Midwife

A registered nurse (R.N.) certified by the American College of Nurse-Midwives. For services to be covered, the nurse-midwife must work under the direction of a doctor, bill for services under the doctor's taxpayer ID, and provide services in line with nurse-midwife certification.

Chiropractic Care

Services provided by a Chiropractor (D.C.) or licensed physician (M.D. Or D.O.) including office visits, diagnostic xrays, manipulations, supplies, heat treatment, cold treatment and massages.

COBRA

The Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of health care coverage in certain circumstances.

Coinsurance

The percentage of the cost of covered expenses a participant must pay after meeting any applicable deductible.

Complete Claim (Proper Claim)

A previously incomplete claim for which a participant has submitted the missing or additional information required for the Plan to make a determination.

Concurrent Care Claim

A claim for a benefit that involves an ongoing course of treatment.

Co-payment

The fixed dollar amount of covered expenses a participant must pay before Plan pays.

Custodial Care

Services and/or care not intended primarily to treat a specific injury or illness (including mental health and substance abuse). Services and care include, but are not limited to:

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that usually can be self-administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.

Deductible

The dollar amount (for individual or family) a participant must pay each year before the Plan begins to pay benefits.

Diagnostic Service

A test or procedure performed for specified symptoms to detect or to monitor a disease or illness and ordered by a physician or professional provider.

Doctor/Physician

A doctor of medicine (M.D.) or doctor of osteopathy (D.O.). The term also includes a chiropractor (D.C.), dentist (D.M.D. or D.D.S.), or a podiatrist (D.P.M.). In all cases, the person must be legally qualified and licensed to perform a service at the time and place of the service.

Durable Medical Equipment

Equipment such as braces, crutches, hospital beds, etc, that is primarily and customarily used to serve a medical purpose that:

- can stand repeated use;
- generally is not useful to a person in the absence of an illness or injury;
- is appropriate for use in the home.

Eligible Provider

Any practitioner or facility offering covered services and acting within the scope of the appropriate license; examples include a licensed doctor, osteopath, podiatrist, chiropractor, hospital, or laboratory.

Employee

A person who works for the Company in an employer-employee relationship.

ERISA

The Employee Retirement Income Security Act of 1974, as amended, a Federal law that governs group benefit plans.

Experimental or Investigational Services

Medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time the Plan makes a determination regarding coverage in a particular case, are determined to be:

- not approved by the U.S. Food & Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use; or
- not demonstrated through authoritative medical or scientific literature published in the U.S. to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- the birth or adoption of a child or placement of a foster child in a participant's home;
- the care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
- a participant's own serious health condition; or
- any qualifying exigency arising from an employee's spouse, son, daughter, or parent being a member of the military on "covered active duty". Additional military caregiver leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your Company for at least one year; you have worked at least 1,250 hours during the previous 12 months; your Company has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the Company. You should contact the Company with any questions you have regarding eligibility for FMLA coverage or how it applies to you.

Formulary

A list of prescription drugs that represent safe, effective therapeutic medications covered by the Plan.

Generic Drug Alternative

A generic drug that is not the exact equivalent of the brand-name drug, but can be used to treat that medical condition. For example, there are generic options to treat high cholesterol.

Generic Drug Equivalent

A generic drug that has the exact same active ingredients as the brand-name drug. When a drug patent expires, other companies may produce a generic version of the brand-name drug. A generic medication, also approved by the Federal Drug Administration (FDA), is basically a copy of the brand-name drug and is marketed under its chemical name. A generic may have a different color or shape than the brand name, but it must have the same active ingredients, strength, and dosage form (i.e., pill, liquid, or injection), and provide the same effectiveness and safety.

Genetic Information

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

GINA

The Genetic Information Nondiscrimination Act of 2008, as amended.

HIPAA

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

HITECH

The Health Information Technology for Economic and Clinical Health Act, as amended.

Hospice

A licensed (if required by the state in which it is located) facility set up to give terminally ill patients a coordinated program of inpatient, outpatient, and home care. The Plan must approve the hospice and treatment plan supervised by a physician.

Hospital

A legally licensed facility that:

- is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals; or
- provides a broad range of 24-hour-a-day medical and surgical services by or under the direction of a staff of doctors and is engaged primarily in providing either:
    - general inpatient medical care and treatment through medical, diagnostic, and major surgical facilities on its premises or under its control; or
    - specialized inpatient medical care and treatment through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital that itself qualifies under the above description, or with a specialized provider of these facilities.

The term hospital does not include a facility that primarily is a place for rest, a place for the aged, or a nursing home.

Illness (or Disease)

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory finding peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Improper Claim

A claim that is not filed according to Plan procedures. A participant or his or her representative will be notified if a claim is determined to be filed improperly. The notice will contain the steps and the time frame that must be followed to resubmit the claim for a determination.

Incomplete Claim

A claim that does not contain sufficient information for a determination to be made. A participant or his or her representative will be notified if a claim is determined to be incomplete. The notice will contain a description of the additional information required and the time frame that must be followed to resubmit the claim for a determination.

Injury

An accidental bodily injury that is the sole and direct result of an accident or a reasonably unforeseeable consequence of a voluntary act by the person. :

In-Network Provider

A health care professional or facility that is contracted by the Plan to provide health care benefits under the Plan.

Leased Employee

Leased employee as defined in the Internal Revenue Code, section 414(n), as amended.

Managed Care

A type of health care delivery system that combines doctor choice and access with lower costs, less paperwork, and prescribed standards for medically necessary treatment.

Medical Condition

A condition for which the individual has sought and received medical treatment.

Medically Necessary

To be medically necessary, all care must be:

- in accordance with standards of good medical practice;
- consistent in type, frequency, and duration of treatment with scientifically based guidelines, as accepted by the Plan;
- required for reasons other than the convenience of the health care provider or the comfort or convenience of the patient;
- provided in a cost-efficient manner and type of setting appropriate for the delivery of that service/supply;
- consistent with the eligible diagnosis of the condition;
- not experimental or investigational, as determined by the Plan; and
- demonstrated through authoritative medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The fact that a doctor performs or prescribes a procedure or treatment or that it may be the only treatment for a particular condition does not mean that it is medically necessary as defined here.

The Plan reserves the right to conduct a utilization review to determine whether services are medically necessary for the proper treatment of the participant and may also require the participant to be independently examined while a claim is pending.

Medicare

The program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Network

A group of doctors, hospitals, and other providers contracted by the Plan to provide health care services for the Plan's members at agreed-upon rates.

Network Pharmacy

A pharmacy contracted by the Plan to provide prescription drug benefits under the Plan.

NMHPA

The Newborns' and Mother's Health Protection Act of 1996, as amended. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

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

Out-of-Pocket Maximum

The maximum amount a participant pays for covered medical expenses (including expenses for covered dependents) in a calendar year. When the out-of-pocket maximum is reached, the Plan pays 100% of eligible covered expenses for the rest of the calendar year.

Participant

An eligible employee who elects to participate in the Plan by completing the necessary enrollment forms.

Post-Service Health Claim

A claim for a benefit under the Plan that is not a pre-service claim.

PPACA

The Patient Protection and Affordable Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

Pre-Service Health Claim

A claim for a benefit that, under the terms of the Plan, requires a participant to receive, in whole or in part, prior approval from the Plan as a condition to receive the benefit.

Prudent Layperson

An individual who possesses an average knowledge of health and medicine and, therefore, is able to determine that the absence of immediate medical attention may result in a serious medical condition for an ill or injured person.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)

Any court order that: 1) provides for child support with respect to the employee's child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN.

Skilled Nursing Facility

A facility that qualifies under the Health Insurance of the Aged and Disabled provisions of the United States Social Security Act (Medicare), as amended; and is approved by the Plan.

Totally Disabled

An employee who is determined as disabled for Social Security purposes.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

A Federal law covering the rights of participants who have a qualified uniformed services leave.

Urgent Care Claim

A claim for medical treatment which, if the regular time periods observed for claims were adhered to, 1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or 2) would, in the opinion of a physician with knowledge of the claimant’s medical condition, subject the claimant to severe pain that cannot be adequately managed. Any claim that a physician with knowledge of the claimant’s medical condition determines to be a “claim involving urgent care” will be deemed to be an urgent care claim. Otherwise, whether a claim is an urgent care claim or not will be determined by an individual acting on behalf of the Plan, and applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

WHCRA

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

Adoption of the Plan

The Perrysburg School District Health and Welfare Benefit Plan, effective 01/01/2020, as amended and restated herein, is hereby adopted as of 01/01/2020. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this _____ day of _____, 201 .

BY: _____

TITLE: _____