

**PLYMOUTH-CANTON COMMUNITY SCHOOLS
EMPLOYEE BENEFIT PLAN**

General Provisions

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Effective January 1, 2008

Restated September 1, 2010

**PLYMOUTH-CANTON COMMUNITY SCHOOLS
454 South Harvey Street
Plymouth, MI 48170**

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INTRODUCTION

Plymouth-Canton Community Schools (“**District**”) sponsors the Plymouth-Canton Community Schools Employee Benefit Plan (the “**Plan**”) for your benefit and the benefit of your family, if you are an eligible employee of the District or its affiliates or subsidiaries that participate in the Plan.

► **BENEFIT PROGRAMS**

The Plan offers the following benefit programs (the “**Benefit Programs**”), but your eligibility for a Benefit Program will depend upon your employment classification by the District (*see* Appendix A):

- A “**Medical Benefit Program**” that provides comprehensive major medical, hospitalization and prescription drug benefits through a Preferred Provider Organization. There are **no** pre-existing condition exclusions or limitations under the medical benefit program. There is a provision under the prescription drug program that requires you to have a generic drug dispensed whenever one is available. If you request a brand name drug when a generic equivalent exists, you must provide the pharmacist with a DAW (Dispense As Written) prescription from the prescribing physician. If you request a brand name without a DAW and a generic equivalent exists, you will pay the cost differential between the generic and brand name plus the co-pay.
 - A “**Dental Benefit Program**” that provides teeth and gum maintenance and treatment benefits through a Preferred Dentist Network.
 - A “**Vision Benefit Program**” that provides benefits for eye exams, contact lenses and prescription eyeglasses through a Preferred Provider Organization.
 - A “**Long Term Disability (‘LTD’) Benefit Program**” that provides you income replacement benefits should you become totally disabled. The current LTD carrier provides an Employee Assistance Plan (EAP) as part of their contract. An EAP is designed to offer support, guidance and resources to help you and your family resolve personal issues. Depending on your classification, the District may or may not pay for LTD benefits. Refer to Appendix A for benefits available by classification.
 - A “**Life/Accidental Death and Dismemberment (‘Life/AD&D’) Insurance Benefit Program**”, providing benefits for you and your beneficiary(ies) in the event of your death, paralysis or loss of your limbs due to an accident (including accidents during business and pleasure travel). Depending on your classification, the District may or may not pay for Life/AD&D benefits. Refer to Appendix A for benefits available by classification.
 - A “**Pre-Tax Payment Benefit Program**,” that allows you to pay with *pre-tax* dollars your share of the cost of applicable benefits under the Benefit Programs that require contributions from you.

- An “**Uninsured Health Care Reimbursement Account (UHCRA) Benefit Program**” that allows you to pay for certain health care expenses on a *pre-tax* basis with no annual maximum for Administrators and Teachers and up to an annual maximum of \$3,000 for all other groups. Effective 09/01/10, the annual maximum for Teachers changed from unlimited to \$5,000.
- A “**Dependent Care Reimbursement Account (‘DCRA’) Benefit Program**” that allows you to pay for certain dependent care expenses on a *pre-tax* basis up to an annual maximum of \$5,000 per household (\$2,500 if you are married, filing separately).
- An “**Opt Out Bonus Program**” is available for Cafeteria and Custodial/Maintenance employees. An Opt Out allows you to receive cash in lieu of benefits in the event you have coverage elsewhere and can provide proof of the other coverage. Cafeteria employees are paid \$600 per year and Custodial/Maintenance employees are paid \$480 per year. You will remain eligible for all other insurance coverage: dental, vision, LTD and Life.

Employees may opt in or out of health insurance annually during the open enrollment period.

The Opt Out Bonus will be prorated for new employees starting after July 1 and for employees who leave the District before the end of June.

The payment will be made in the last pay in July.

► **PREFERRED PROVIDERS FOR MEDICAL AND DENTAL BENEFIT PROGRAMS**

The Medical Benefit Program offers medical benefits and the Dental Benefit Program offers dental benefits through a PPO. A “**PPO**” or “**Preferred Provider Organization**” is a group of hospitals and physicians that contract to provide comprehensive medical services for the Medical Benefit Program and dental services for the Dental Benefit Program on a discounted fee-for-service basis. These providers are referred to as network providers and they have agreed through the contract to accept an approved amount as payment in full from the Claims Administrator for covered services (but you remain responsible for any Deductible, Coinsurance and/or Copayment). When network providers are used, the levels of coverage are higher and out-of-pocket expenses are lower. When receiving care from a network provider, you will need to show your identification card. The PPO also offers out-of-network coverage. When you receive care from an out-of-network but participating provider, levels of coverage are lower and out of pocket expenses are higher. Out-of-network but participating providers may require you to pay the bill up front and file a Claim form for reimbursement from the Plan. If you receive services from an out-of-network nonparticipating provider and the nonparticipating provider will not accept the approved amount as payment in full for covered services, you will be responsible for the difference between the approved amount and the provider’s charges, in addition to any Deductible, Coinsurance and/or Copayment. The reimbursements are based on what is determined to be the usual, reasonable and customary fee for the service provided.

Lists of participating network physicians, hospitals, dentists and other health care professionals for the Medical and Dental Benefit Programs are furnished separately at no charge to you. You can obtain information relating to network providers from the Plan Administrator, from the Claims Administrator's website for the Medical Benefit Program or the Dental Benefit Program. Refer to Appendix B for the website, address and phone number for the Medical, and/ Dental Benefit Programs' Claims Administrators. Before using a particular provider for a health or dental care service, you should confirm that the provider is a participating network provider under the Medical Benefit Program or Dental Benefit Program.

► FUNDING ARRANGEMENTS FOR BENEFIT PROGRAMS

Some of the Benefit Programs are “**Self-funded**” by the District. That means the District pays the Benefit Programs' benefits from its general fund and the benefits are not provided through insurance. Other Benefit Programs are insured. That means the District's contributions and your contributions (if any) are used to pay insurance premiums to insurance companies, and the insurance companies pay the benefits under insurance policies or contracts. Appendix B lists which Benefit Programs are Self-funded or insured.

For each insured Benefit Program, there is an insurance contract or policy that serves as the official Plan document for that Benefit Program. The insurer for each insured Benefit Program also prepares one or more booklets, summaries and/or certificates (collectively, “**Booklets**”) that describe in detail the benefits available under that Benefit Program. The Booklets, together with this document, are the Summary Plan Description (“**SPD**”) for the insured Benefit Programs. For any insured Benefit Program, where there arises any conflict between the terms of this document, the District's Booklet, and the insurance policy or contract for that Benefit Program, the terms of the insurance policy or contract will control.

Third-party administrators that administer the Self-funded Benefit Programs also produce booklets and/or summaries (collectively, “**Booklets**”) describing your benefits under the Self-funded Benefit Programs. The Booklets and this document together are the Plan document and SPD for the Self-funded Benefit Programs.

A portion of the Plan is a cafeteria plan under Section 125 of the Code with a pre-tax premium contribution program, a health flexible spending account and a dependent care flexible spending account. This document is the Plan document and SPD for the cafeteria plan.

► EFFECTIVE DATE

This document, and the Benefit Programs' Booklets, describe the Plan as in effect on January 1, 2010. Read these documents carefully and keep them for future reference. For the purpose of eligibility and participation, the provisions in this document supersede any provisions stated in the Booklets by the Claims Administrator. If you have any questions about any of the Benefit Programs or the Plan in general, call the District's Benefits Department at 734.416.4834 or e-mail dawn.schaller@pccsmail.net. Where a term in this document has a Plan-specific meaning, it is capitalized. When that term is defined, it also appears in bold print and quotation

marks. For your convenience, there is an Index of Defined Terms at the end of this document with page references to each defined term.

ELIGIBILITY

► EMPLOYEE Eligibility

If you are an employee of the District and you are not an Excluded Employee, you are eligible to participate in the Benefit Programs that apply to your employee classification on the date you complete a Waiting Period. See Appendix A for the Benefit Programs that are available to your employee classification.

You are considered a **“Full-time”** employee of the District provided you work the number of hours required by your classification. For example, a Teacher must be regularly scheduled to work at least 37.5 hours per week in order to be eligible.

You are *not* eligible to participate in the Plan if the District classifies you as a substitute employee. If you are an independent contractor for the District, you are not eligible for the Plan, even if you are later determined to be an “employee” as a result of a judicial or administrative determination.

Waiting Period

If you are a Full-time employee of the District, your **“Waiting Period”** ends as follows:

CLASSIFICATION	WAITING PERIOD	FULL-TIME CONTRIBUTIONS REQUIRED	LESS THAN FULL-TIME CONTRIBUTIONS REQUIRED
Superintendent, Assistant Superintendent, Executive Directors, Affiliated Administrators and Non-Affiliated Administrators, Teachers (working 37.5 hours or more per week)	Date of hire (for Medical and Life), first of the month following date of hire for all other benefits.	Superintendent, Assistant Superintendent, Executive Directors, Affiliated Administrators and Non-Affiliated Administrators	Teachers and Administrators working less than 37.5 hours per week pay for coverage based on the percentage of time they are not working (e.g., a Teacher working 60% of a full-time position, will pay 40% of the cost for coverage)
Bus Monitors, Cafeteria (working under 25 hours), Cafeteria (working 25 hours or more weekly) and Vocational Technicians (4 hours or more daily)	60 working days (for Medical and Life), first of the month following 60 working days for all other benefits.	N/A	N/A

FT) (less than 4 hours daily PT)			
Bus Monitors (less than 4 hours per day), Clerical, Custodial/Maintenance, Dispatchers, Extended Day (working 20 hours or more per week), Early Childhood (working 20 hours or more per week), Plant Engineers, Paraprofessionals (20 hours or less), Paraprofessionals, Security Guards, Transportation	90 working days (for Medical and Life), first of the month following 90 working days for all other benefits.	N/A	Clerical, Custodial Maintenance & Plant Engineers working less than 40 hours per week (or certain clerical positions at 37.5 hours) pay for coverage based on the percentage of time they are not working.
Licensed Techs (working 40 hours or more per week)	6 months (for Medical and Life), first of the month following 6 months for all other benefits.	N/A	Licensed Techs working less than 40 hours per week pay for coverage based on the percentage of time they are not working.

Excluded Employees

If you are an Excluded Employee you are not eligible to participate in the Plan.

“**Excluded Employees**” include:

Non-union, non-benefited at will Independent Contractors.

Actively at Work

For the Life/AD&D and LTD Benefit Programs, you must also be Actively at Work during your entire Waiting Period and on the date your Waiting Period ends. “**Actively at Work**” means that you are performing the material duties of your job as required by your job at the District’s usual place of business or at any other place the District requires you to go. The District considers you Actively at Work during paid vacations, regularly scheduled days off, holidays or paid personal days. The Booklets for the Life/AD&D and LTD Benefit Programs have a more detailed description of the Actively at Work requirement. Please refer to the Booklets for more information on this requirement.

► REHIRED EMPLOYEE ELIGIBILITY

If you were eligible for the Plan as a Full-time employee of the District and you terminate employment with the District, you will be treated as a newly hired employee and you will need to satisfy the Waiting Period.

If you are an employee who is laid off by the District and you return to work as a Full-time employee of the District within six months of your layoff date, then no Waiting Period will apply upon your rehire date for Medical and Life coverage. Dental, Vision and LTD are reinstated on the first of the month following your return to work.

► DEPENDENT ELIGIBILITY

Members of your family may also be eligible for coverage under the Medical, Dental, Vision, and UHCRA Benefit Programs. (See the DFSA Benefit Program for dependent eligibility under that Benefit Program.) An “**Eligible Dependent**” for the Benefit Programs is:

- Your Spouse, unless legally separated.
- Your unmarried Child until the end of the calendar year in which they turn 19 years of age.
- Your unmarried Child who is:
 - age 19 through the end of the calendar year in which they attain 25 years of age,
 - dependent on you for more than half of their support,
 - a member of your household,
 - related to you by blood, marriage, legal adoption, or legal guardianship,
 - enrolled as a full-time student at an accredited college, university or any other accredited school (carrying the minimum required by that institution) for at least five months of the year or had a gross income of less than four times the personal exemption.

(You must respond to the notice that is sent out by the Benefits Department confirming that your 19-25 year old dependent is eligible for coverage before your Child turns age 19 and annually thereafter).

- Your unmarried Child of any age who meets all of the following requirements:
 - the Child was totally and permanently disabled before age 19 and you notify the Plan Administrator in writing of the condition within 31 days of the date your Child turns age 19,

- the Child’s disability is due to a mental or physical disability that prevents the Child from being self-supporting,
 - the Child is dependent on you for his or her support, and you report the Child as a dependent on your federal income tax returns, and
 - you provide proof of these facts to the Plan Administrator and you provide continuing proof as requested by the Plan Administrator.
- A Child who must be provided health coverage under the Plan as required by a Qualified Medical Child Support Order.

For the Medical and Dental Benefit Programs, an Eligible Dependent does not include any person who is in the military of any country or subdivision of any country; lives outside the United States or Canada; or is insured under a group policy as an employee.

You must notify the Plan Administrator on or before the date that is 30 days after any status change that would result in a dependent no longer being eligible for Plan participation (for example, your Spouse in the event of a divorce). For COBRA Continuation Coverage purposes, however, you have 60 days to provide the District with notice of divorce or that a Child is no longer an Eligible Dependent. The Plan has the right to recover from you any payments the Plan makes on behalf of an individual who is no longer an Eligible Dependent.

“**Spouse**” means the one person to whom you are legally married under the laws of the State in which you reside, and who is the opposite gender from you.

“**Child**” includes your natural child, legally adopted child, child placed with you in anticipation of the child’s being adopted, a step-child (as long as the natural parent remains married to the employee), foster child, or child by virtue of legal guardianship. Your Child under the age of 19 will be eligible for coverage even if the Child is born out of wedlock, is not claimed by you as a dependent for federal income tax purposes, or does not reside with you. In connection with any adoption or placement for adoption, Child means an individual who has not attained the age of 18 as of the date of such adoption or placement for adoption.

The District or the Claims Administrator may require proof of an individual’s status as an Eligible Dependent. If you do not provide this proof upon request, your dependent will not be eligible for coverage under the Plan.

PARTICIPATION

To start participating in the Plan, you need to fill out the Benefit Program enrollment form you will receive from the Benefits Department (“**Enrollment Form**”) and submit the completed Enrollment Form to the Benefits Department. On the Enrollment Form, you select from the various available Benefit Programs the coverage you prefer and enroll yourself and your Eligible Dependents. You will also agree on the Enrollment Form to have your pay reduced for any Benefit Contributions.

► INITIAL ENROLLMENT PERIOD

As a newly hired Full-time employee of the District (other than Excluded Employees), you may participate in the Benefit Programs that are available to you after you complete the Waiting Period, as long as you complete and return the Enrollment Form to the Benefits Department before the end of your Waiting Period (“**Initial Enrollment Period**”). You will need to enroll your Eligible Dependents during your Initial Enrollment. The District will automatically enroll you after your Waiting Period in the Benefit Programs that do not require you to make any elections or Benefit Contributions, but you need to return the Enrollment Form to the Benefits Department as it contains your beneficiary designations and other important information.

After you return your Enrollment Form to the Benefits Department, your participation in the Plan will start on the date following the last day of your Waiting Period.

If you do not enroll yourself (and your Eligible Dependents) in the Benefit Programs for which you must elect coverage during your Initial Enrollment Period, you will not receive coverage under those Benefit Programs and you may not enroll in them until the next Open Enrollment Period, Special Enrollment Period or until you experience a Change Event. The benefit choices you make during your Initial Enrollment Period will remain in effect for the remainder of the Plan Year, unless you have a Special Enrollment Period or you experience a Change Event and you make new benefit elections.

► OPEN ENROLLMENT PERIOD

Each year, the District establishes an “**Open Enrollment Period**”, which is from May 1 – May 31 of each year. During the Open Enrollment Period, you can enroll for the first time or make new benefit choices for the upcoming Plan Year by completing the Enrollment Form and returning it to the Benefits Department. You may also enroll Eligible Dependents during the Open Enrollment Period. If you do not enroll or make new benefit choices during the Open Enrollment Period, then you must wait to enroll or to change your benefit choices until the next Open Enrollment Period, Special Enrollment Period, or until you experience a Change Event.

For all Benefit Programs, except the UHCRA and DFSA Benefit Programs, the benefit choices you make during the Open Enrollment Period will take effect on September 1st and will remain in effect until August 31st. For the UHCRA and DFSA Benefit Programs, your choices during the Open Enrollment Period (June 1st – June 30th) will take effect on September 1st and will remain in effect until August 31st. You may terminate coverage at any time unless you are required to make a contribution toward that coverage.

If you previously enrolled in the Plan, but you do not change your existing Benefit Program choices during a later Open Enrollment Period, your Benefit Program choices for the previous Plan Year (other than the UHCRA and DFSA Benefit Program) and applicable Benefit Contributions for those benefits will remain in effect during the upcoming Plan Year, unless the Plan no longer offers a benefit option or Benefit Program. You will receive no coverage, however, under the UHCRA and DFSA Benefit Programs unless you affirmatively elect to enroll in those Benefit Programs each year.

If you are eligible to participate in the Plan, and the Open Enrollment Period falls during a time when you are on a District approved FMLA leave of absence, the District will contact you so that you may make your Benefit Program choices during the Open Enrollment Period.

► SPECIAL ENROLLMENT PERIOD

You and your Eligible Dependents may enroll in the Medical and Dental Benefit Programs under certain circumstances. If you declined coverage under the Medical or Dental Benefit Program when it was first available because of other health coverage, and that coverage is later lost on account of:

- exhaustion of COBRA continuation coverage,
- Lost Eligibility for Other Coverage, or
- termination of employer contributions towards the other coverage,

you and your Eligible Dependents may enroll in the Medical and Dental Benefit Programs on or before the date that is 30 days after the date you lost that other coverage.

“**Lost Eligibility for Other Coverage**” includes a loss of other health coverage as a result of: (i) your legal separation or divorce, a dependent’s loss of dependent status, death, termination of employment or reduction in number of hours of employment; (ii) attaining your lifetime maximum under another group health plan; or (iii) you no longer reside, live or work in the service area of a health maintenance organization in which you participated. Your enrollment will take effect on the date following your loss of coverage and your timely request to enroll.

If you initially declined enrollment for yourself or your Eligible Dependents and you later have a new Eligible Dependent because of marriage, birth, adoption or placement for adoption, you may enroll yourself and your new Eligible Dependents (including an Eligible Dependent Spouse if you have a new Eligible Dependent Child), as long as you request enrollment on or before the date that is 30 days after the marriage, birth, adoption or placement for adoption. For example, if you and your Eligible Dependent Spouse have a Child, you may enroll yourself, your Eligible Dependent Spouse and your new Child in the Medical and Dental Benefit Programs, even if you were not previously enrolled. You will not, however, be able to enroll existing Eligible Dependent Children for whom coverage has been waived in the past. These 30-day periods are “**Special Enrollment Periods.**”

For birth, adoption or placement for adoption, your or your Eligible Dependent’s participation will start as of the date of the birth, adoption or placement for adoption as long as you timely requested enrollment. For marriage, your or your Eligible Dependent’s participation will start no later than the first of the month following the date of the marriage provided you timely submit to the Benefits Department the Enrollment Form and proof of your dependent’s status as an Eligible Dependent.

► ENROLLMENT PERIODS FOR NEW ELIGIBLE DEPENDENTS

You will need to enroll your new Eligible Dependents on or before the date that is 30 days after the event by which they became your Eligible Dependent (for example, a new Spouse after your marriage or your baby is born). If you do not add new Eligible Dependents within this 30-day period, you cannot enroll them until the next Open Enrollment Period, Special Enrollment Period or unless a Change Event occurs. You will need to provide proof of your dependent's status as an Eligible Dependent.

- **Medicaid and CHIP.** Effective as of April 1, 2009, if you or your Eligible Dependent Children are eligible for, but not enrolled in, the Medical or Dental Benefit Program and you or your Eligible Dependent Children:
 - lose coverage under Medicaid or a State child health plan (CHIP), or
 - become eligible for a premium assistance subsidy through Medicaid or CHIP,

you and your Eligible Dependent Children may enroll in the Medical or Dental Benefit Program, as long as you request enrollment on or before the date that is 60 days after the loss of coverage or the date you or your Eligible Dependent Children became eligible for the premium subsidy.

► PARTICIPATION DURING A FMLA LEAVE OF ABSENCE

Under the Family and Medical Leave Act of 1993, as amended (“FMLA”), you may qualify for up to a 12 week medical leave of absence. With District approval, you may take an FMLA leave of absence and remain a participant in the Plan during this time. You will be entitled to receive the same Medical, Dental, Vision and UHCRA Benefit Program benefits and EAP benefits that you were receiving immediately before the start of your FMLA leave. The District also intends to allow you to continue to receive all other Plan benefits (other than the DFSA Benefit Program benefits if your FMLA leave lasts longer than two weeks) during your FMLA leave, to the extent possible.

If your FMLA leave lasts longer than two calendar weeks, your participation in the DFSA Benefit Program will end. You will be allowed to make up any missed amounts upon return from your FMLA leave, if you return from FMLA leave within the same calendar year, but expenses incurred during your FMLA leave will not be eligible for reimbursement.

The following applies to your District approved FMLA leave of absence:

- If you do not wish to receive some or all of the coverage during your leave that you were receiving just prior to your leave, you must inform the Benefits Department before the start of your leave. Benefits under the Plan will terminate on the date you start your leave of absence.
- If you wish to continue your participation in the Plan, and you are currently required to contribute a certain amount for your coverage, you must make arrangements with the Benefits Department to pay for the coverage you wish to maintain during the course of your leave. You can pay your Benefit Contributions:

- in advance of your leave,
 - when you return from your leave by increasing your pre-tax or after-tax Benefit Contributions (for pre-tax Benefit Contributions, the Plan Administrator may only collect pre-tax Benefit Contributions that you owe for the current Plan Year within the same Plan Year), or
 - during your leave by sending a check monthly to the Benefits Department.
- Your eligibility to continue any coverage that requires payments from you may be cancelled if you do not make the required payments within 30 days of the payment due date.
 - If your leave extends beyond 12 weeks your participation in the Plan will end on the first of the month following the date you should have returned to employment with the District (unless you continue to be out on paid sick leave). You may, however, be eligible to continue your coverage under the Medical, Dental, Vision and UHCRA Benefit Programs at your cost, for limited periods of time (see the section titled “COBRA Continuation Coverage”).
 - If the District advances money by making Benefit Contributions for you, in whole or in part, it can recoup the amounts advanced through payroll deductions upon your return to employment following your leave. If you do not return from an FMLA qualified leave of absence for reasons other than the continuation of a serious health condition or circumstances beyond your control, you must reimburse the District for the entire cost to the District for providing the medical and dental benefits during your leave and for your share of the cost of the other benefits the District continued to provide to you during your leave. Benefit Contributions may also be deducted while you are on leave or once you return from your leave.
 - When you return from your FMLA leave, you are not required to satisfy the Waiting Period under the Benefit Programs.

Once you are no longer on FMLA leave but you remain on sick leave, (meaning you are using sick time from your sick bank), benefits continue until the first of the month following exhaustion of the sick bank. You must obtain District approval before taking FMLA leave. You should refer to the District’s Leave of Absence Policy or your Collective Bargaining Agreement for additional information on your Leave of Absence Provisions and consult with your Human Resources Department before taking any FMLA leave.

All employees are offered (employee paid) leave of absence insurance (Medical, Dental, Vision and Life) for one year from the date of the exhaustion of FMLA or your sick bank, except for Teachers (if on LTD, the District will pay health benefits for 6 months; dental, vision and life are offered on an employee paid basis for one year. After 6 months of paid health while on LTD, teachers will then be offered the remaining 6 months under Leave of Absence benefits paid by the employee). For the Transportation group, once you go on an unpaid Leave of Absence, the

District pays Medical benefits for one year. Dental, Vision and Life are offered on an employee paid basis for one year. Once Leave of Absence benefits have been exhausted, you will be offered COBRA Continuation Coverage for Medical, Dental, Vision and UHCRA coverage.

► QUALIFIED CHANGE IN STATUS EVENTS

You cannot change your Benefit Program elections during the Plan Year (or for the UHCRA and DFSA Benefit Programs, during the calendar year), unless you experience a Qualified Change in Status Event (“**Change Event**”), and the change you want to make is consistent with the Change Event.

Change Events for all Benefit Programs

Any of the following events are Change Events for all of the Benefit Programs.

- You or your Eligible Dependent become eligible or ineligible for coverage on account of a change in:
 - legal marital status (for example; marriage, divorce, legal separation, annulment^{*}) ;
 - number of dependents (for example; birth, death, adoption, placement for adoption);
 - your or your Eligible Dependent’s employment status (for example; termination or commencement of employment, taking or returning from an unpaid FMLA leave of absence);
 - your or your Eligible Dependent’s job status (for example; part-time to full-time, or union to non-union, or *vice versa*);
 - residence or work site; or
 - an Eligible Dependent’s status (for example, a dependent becomes eligible or ineligible for benefits under the Plan)^{**} .
- A change in coverage due to an election made by your Spouse or dependent during an open enrollment period under the Spouse’s or dependent’s employer’s benefit plan that relates to a period that is different from the Plan Year for this Plan (for example, your Spouse’s open enrollment period is in January and your Spouse changes coverage). (**This is not a Change Event for the UHCRA Benefit Program.**)

* You must provide proof of a change in your legal marital status to the Benefits Department.

** You must provide proof of a change in an Eligible Dependent’s status to the Benefits Department.

- A change in the availability of benefit options or coverage (addition or removal) under the Plan's Benefit Programs (for example, a new HMO or PPO option is added to the Medical Benefit Program). **(This is not a Change Event for the UHCRA Benefit Program.)**
- A significant increase or decrease in the cost of coverage during the Plan Year (meaning on an annual basis at least a \$500 change in the cost of health coverage). **(This is not a Change Event for the UHCRA Benefit Program.)**

Additional Change Events for the Medical, Dental, Vision and UHCRA Benefit Programs

In addition to the Change Events listed above, you may change your benefit elections for the Medical, Dental, Vision and UHCRA Benefit Programs if:

- you or your Eligible Dependent becomes eligible for COBRA Continuation Coverage or extended coverage under USERRA;
- a judgment, decree, or order, resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order), is entered by a court of competent jurisdiction that requires accident or health coverage for your Child under this Plan;
- you or your Eligible Dependent becomes enrolled or loses coverage under Part A or Part B of Medicare or Medicaid (other than coverage solely with respect to the distribution of pediatric vaccines); or
- for the Medical and Dental Benefit Programs only, you or your Eligible Dependent are eligible for a Special Enrollment Period.

Additional Change Events for the DFSA Benefit Programs

In addition to the Change Events listed above, you may change your benefit elections for the DFSA Benefit Program if:

- you experience a significant increase or decrease in your Eligible Dependent Care Expenses (meaning on an annual basis at least a \$500 change) for a dependent care provider who is not a relative;
- your dependent care provider changes; or
- you take or return from a paid FMLA leave of absence that lasts longer than two calendar weeks.

Consistency Rule

Your election changes must be consistent with the Change Event that affects your coverage under the Benefit Program. For example:

- if one of your Eligible Dependents no longer qualifies as an Eligible Dependent, you could cancel coverage for that dependent, but you could **not** cancel coverage for your other Eligible Dependents; or
- if you have single coverage and you marry, you may elect family coverage.

Some of the Change Events may allow you the option of either adding or removing coverage. For example, your Spouse changing an election under his or her employer's plan may allow you to add or remove coverage under this Plan, so long as your choice is consistent with your Spouse's election.

If you are not sure the election change you would like to make is consistent with the Change Event, you should contact the Benefits Department.

Procedures for Changing Elections Mid-Year

If you want to change a Benefit Program election because of one of these Change Events, you may do so by filing a change event form with the Benefits Department, identifying the event that resulted in the change and specifying how you want your elections changed. You may obtain this form from the Benefits Department. You must submit your request on or before the date that is 30 days after the date of the Change Event. If the Change Event is the birth or adoption of a dependent Child, the change in coverage will take effect as of the date of the Change Event, even though you file your change request after the date of birth or adoption. For all other Change Events, the change in coverage will take effect no later than the first of the month following the Change Event and your timely requested change.

If you file a request more than 30 days after the Change Event, no changes will be made to your elections or Benefit Contributions, but you may make the necessary change during the next Open Enrollment Period.

Special Rule for the UHCRA and DFSA Benefit Programs

You may not reduce your benefit elections for the UHCRA and DFSA Benefit Programs below the amount already reimbursed to you prior to your Change Event.

► END OF PARTICIPATION IN THE PLAN

Your participation in the Plan will end under the following conditions:

- You terminate employment or you change to ineligible status. Your participation ends on the first of the month following the date you terminate employment or change to ineligible status.

- You do not return to employment after your District approved FMLA leave of absence or you do not choose to take advantage of the additional Leave of Absence extension of coverage. For the Medical, Dental, Vision, LTD, Life/AD&D, Pre-Tax Payment and UHCRA Benefit Programs, your participation ends on the first day of the month following the date you should have returned to employment with the District. For the DFSA Benefit Program, your participation ends on the first day of your FMLA leave of absence.
- You are laid off by the District. Your participation ends on the first of the month following your date of layoff.
- You cancel your participation in a Benefit Program during an Open Enrollment Period. Your participation in that Benefit Program will end on the last day of the current Plan Year.
- You cancel your coverage under a Benefit Program after a Change Event. Your participation will end the first of the month following the date you timely notify the District of the Change Event.
- For the Benefit Programs that require Benefit Contributions, you stop making those Benefit Contributions. Your participation in the Benefit Program will end on the last date for which you have made Benefit Contributions for that Benefit Program.
- The District terminates the Plan, a Benefit Program, or insurance contract (without renewing it). Your participation will end on the effective date of any Plan, Benefit Program or insurance contract termination.

An Eligible Dependent's coverage under any Benefit Program will end as follows:

- on the date your coverage under that Benefit Program terminates;
- at the end of the month that the dependent is no longer an Eligible Dependent;
- at the end of the month that you cancel coverage due to a Change Event and the timely notice of it; or
- for an Eligible Dependent who is covered by the Plan under the terms of a Qualified Medical Child Support Order, on the date coverage ends according to the terms of the Qualified Medical Child Support Order.

MICHELLE'S LAW CONTINUATION COVERAGE

Effective December 1, 2009, your Eligible Dependent Child who is participating in the Plan as a full-time student at an accredited college or university, may take up to a one year Medically

Necessary Leave of Absence and continue coverage under the Medical and Dental Benefit Programs.

- A. “Medically Necessary Leave of Absence” is a leave of absence or change in enrollment status that:
- Commences while the Eligible Dependent Child is suffering from a serious illness or injury;
 - Is medically necessary; and
 - Causes the Child to lose full-time student status for purposes of the Plan (for example, the Child carries less than 12 credit hours or is enrolled for less than five months during the Plan Year or has gross income that is greater than 4 times the personal exemption allowance).

Your Eligible Dependent Child’s treating physician must certify in writing that a leave of absence due to the Child’s serious illness or injury is medically necessary and you must provide a copy of this written certification to the Benefits Department. Your Eligible Dependent Child’s coverage may terminate prior to the end of the one year Medically Necessary Leave of Absence for the reasons stated in the section of this Plan entitled “end of Participation in the Plan” or according to the terms of the applicable Booklets.

COBRA CONTINUATION COVERAGE

Under certain circumstances you or your Eligible Dependents covered by the Plan (“**Covered Dependents**”) have the right, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“**COBRA**”), to continue coverage under the Medical, Dental, Vision and UHCRA Benefit Programs and the EAP (“**COBRA Continuation Coverage**” or “**Continuation Coverage**”). COBRA Continuation Coverage is available to you and to Covered Dependents when you or they would otherwise lose group health coverage. This section generally explains COBRA Continuation Coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. COBRA Continuation Coverage for the Plan is administered by the District.

► QUALIFYING EVENTS

COBRA Continuation Coverage is available if you are enrolled in the Medical, Dental, Vision or UHCRA Benefit Programs or the EAP and you and your Covered Dependent’s enrollment would otherwise end on account of a “**Qualifying Event**”. COBRA Continuation Coverage is offered to each person who is a Qualified Beneficiary. A “**Qualified Beneficiary**” is someone who will lose coverage under the Plan because of a Qualifying Event.

You will become a Qualified Beneficiary if you will lose your coverage under the Plan’s Medical, Dental, Vision or UHCRA Benefit Programs or the EAP because either of the following Qualifying Events occurs:

- your hours of work are reduced (or you move from a benefiting to a non-benefiting position with the District); or
- your employment ends for any reason other than your gross misconduct.

Your Covered Dependent Spouse will become a Qualified Beneficiary if coverage under the Plan's Medical, Dental, Vision or UHCRA Benefit Programs or the EAP will be lost because any of the following Qualifying Events occur:

- your death;
- your hours of employment are reduced (or you move from a benefiting to a non-benefiting position with the District);
- your employment ends for any reason other than your gross misconduct;
- you become entitled to Medicare benefits (under Part A, Part B, or both); or
- you become divorced or legally separated from your Spouse.

Your Covered Dependent Child will become a Qualified Beneficiary if he/she loses coverage under the Plan's Medical, Dental, Vision or UHCRA Benefit Programs or the EAP because any of the following Qualifying Events happens:

- your death;
- your hours of employment are reduced (or you move from a benefiting to a non-benefiting position with the District);
- your employment ends for any reason other than your gross misconduct;
- you become entitled to Medicare benefits (under Part A, Part B, or both);
- you become divorced or legally separated from your Spouse; or
- your child stops being eligible for coverage under the Plan's Medical, Dental, Vision or UHCRA Benefit Programs or the EAP as an Eligible Dependent.

The Plan offers COBRA Continuation Coverage to Qualified Beneficiaries only after the Benefits Department has been notified that a Qualifying Event has occurred. When the Qualifying Event is the termination of your employment or a reduction of your hours of employment, your death, or your entitlement to Medicare benefits (under Part A, Part B, or both), the District must notify the Benefits Department of the Qualifying Event within 30 days of any of these events.

For the other Qualifying Events (divorce or legal separation or a dependent Child's loss of eligibility for coverage as an Eligible Dependent), you or a Qualified Beneficiary with respect to the Qualifying Event, or a person acting on your or their behalf, must notify the Benefits Department in writing **within 60 days** after the latest of:

- the date of the Qualifying Event;
- the date on which you or a Covered Dependent loses (or would lose) coverage under the Plan's Medical, Dental, Vision or UHCRA Benefit Programs or the EAP; or
- the date on which you or a Covered Dependent are informed through this document or an initial COBRA notice, of both your obligation to provide the notice of the Qualifying Event and the Plan's procedures for providing the notice to the Benefits Department.

The notice must include:

- the name of the employee or former employee who is or was a Plan participant;
- a description of the Qualifying Event;
- the date of the Qualifying Event; and
- the name(s), address(es) and Social Security number(s) of the employee and/or Covered Dependents involved in the Qualifying Event.

You must provide this written notice to the Benefits Department at the following address:

Benefits Department
Plymouth-Canton Community Schools
454 South Harvey Street
Plymouth, MI 48170

The timely provision of the notice by one individual will satisfy the notice requirement on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event. After the Benefits Department receives notice relating to a divorce, legal separation, a dependent's loss of dependent status, or a Qualified Beneficiary's disability described in the section below titled "Disabled Individuals" and it is determined that you or your Covered Dependents do not qualify for such coverage, you or they will be provided written notice within a reasonable period of time explaining why COBRA Continuation Coverage is unavailable.

If you, a Qualified Beneficiary, or a person acting on your or his or her behalf, do not provide the notice to the Benefits Department within the time limit explained above, coverage under the Plan's Medical, Dental, Vision and UHCRA Benefit Programs or the EAP cannot be continued.

After a Qualifying Event has occurred, you and your Covered Dependents will be notified about your/their right to COBRA Continuation Coverage. The District, as the Plan Administrator,

has 44 days from the later of the date of the loss of coverage or the Qualifying Event to provide you and your Covered Dependents with a notice of your right to elect COBRA Continuation Coverage.

► ELECTING COBRA CONTINUATION COVERAGE

If it is determined that you and each of your Covered Dependents qualify for COBRA Continuation Coverage, each of you may individually decide whether or not to continue coverage. You and each of your Covered Dependents will have the right to elect the same coverage under the Medical, Dental, Vision or UHCRA Benefit Programs, or EAP in which you were enrolled immediately before the Qualifying Event. Both you and your Spouse may elect COBRA Continuation Coverage, or only one of you may choose it. Spouses may elect coverage for each other and parents may elect to Continue Coverage on behalf of their Covered Dependent Children. **If you or your Covered Dependent wants to elect Continuation Coverage, you must do so within 60 days of the date the notice of your right to elect COBRA Continuation Coverage was sent by the Benefits Department.**

As long as you elected and you are covered by the COBRA Continuation Coverage during the Plan's Open Enrollment Period, you may make changes to your Medical, Dental and Vision Benefit Program coverage during the Open Enrollment Period, including adding new coverage or changing your options under the Medical Benefit Program.

► PREMIUM PAYMENTS

COBRA Continuation Coverage is at your or your Covered Dependent's expense. The monthly cost of COBRA Continuation Coverage will be included in the notice sent to you. The amount you must pay for COBRA Continuation Coverage will not exceed 102 percent of the cost for this coverage to the Plan (including both the District's and your contributions) for a similarly situated Medical, Dental, Vision or UHCRA Benefit Program or the EAP (as applicable) participant or beneficiary who is not receiving COBRA Continuation Coverage (or, in the case of an extension of COBRA Continuation Coverage due to a disability, 150 percent of that cost). You will have to pay COBRA premiums on an after-tax basis.

For coverage to continue, the first premium must be received by the date stated in the notice sent to you. Normally, this date will be 45 days after COBRA Continuation Coverage is elected. Premiums for every following month of Continuation Coverage must be paid monthly on or before the premium due date stated in the notice sent to you. There is a 30-day grace period for these monthly premiums. If they are not paid within 30 days after their due date, COBRA Continuation Coverage will end as of the first day of that period of coverage and cannot be reinstated. If a partial premium payment is made that falls short of the current amount due by a minimal amount, you will be notified, and, if the shortfall is not paid within 30 days of the date the notice is received, COBRA Continuation Coverage will end as of the first day of that monthly period of coverage.

► DURATION OF COVERAGE

COBRA Continuation Coverage for you and/or your Covered Dependents will start on the date the Qualifying Event occurs and may continue until the earliest of the following:

- 18 months should your employment end and/or your hours be reduced.

- 29 months should you or a Covered Dependent qualify for a disability extension (refer to “Disabled Individuals,” below).
- For your Covered Dependents, 36 months in the event of your divorce or legal separation, your death, or your becoming entitled to Medicare benefits (under Part A or Part B, or both), or your Covered Dependent Child’s loss of dependency status.
- The date on which a premium payment was due but not paid.
- The date after the date a Qualified Beneficiary elects COBRA Continuation Coverage that the Qualified Beneficiary first becomes covered under another employer’s group health plan without an exclusion or limitation affecting coverage of his or her pre-existing condition, if any.
- The date, after the date of his or her election of COBRA Continuation Coverage, the Qualified Beneficiary first becomes entitled to Medicare benefits (under Part A or Part B, or both).
- The date the District terminates all of its group health plans.
- For the UHCRA Benefit Program, the last day of the Plan Year in which the Qualifying Event occurs.

If you or a Covered Dependent’s COBRA Continuation Coverage is terminated for any reason before the maximum period of coverage to which you were entitled, you or your Covered Dependent will be notified of that fact and provided with an explanation of why Continuation Coverage was terminated.

► NEWBORNS AND ADOPTED CHILDREN

If you or your Spouse elect COBRA Continuation Coverage, any Child born to or adopted by you and your Spouse during the period of Continuation Coverage will also be a Qualified Beneficiary, and be entitled to Continuation Coverage for the maximum period of coverage available to any family member, as long as you notify the Benefits Department within 30 days of the birth or adoption.

► SECOND QUALIFYING EVENT

If COBRA Continuation Coverage was elected by a Covered Dependent because your employment ended or your hours were reduced and if, during the period of Continuation Coverage, another Qualifying Event occurs, the maximum period of Continuation Coverage for the Covered Dependent is extended for up to an additional 18 months (that means, to a maximum of 36 months from the date your employment ended or your hours were reduced). Continuation Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, *etc.*

You or the Covered Dependent, or a person acting on your or their behalf, must notify the Benefits Department in writing within 60 days after the latest of:

- the date of the second Qualifying Event;
- the date on which the Covered Dependent would lose coverage under the Plan as a result of the second Qualifying Event; or
- the date on which you or the Covered Dependent are informed, through receipt of this document or an initial notice of COBRA Continuation Coverage, of both your obligation to provide the notice of the Qualifying Event and the Plan's procedures for providing the notice to the Benefits Department.

The notice must include:

- the name of the employee or former employee who is or was a Plan participant;
- a description of the second Qualifying Event;
- the date of the Qualifying Event; and
- the name(s), address(es) and Social Security number(s) of the Covered Dependents involved in the Qualifying Event.

The timely provision of the notice by one individual will satisfy the notice requirement on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event. If you or the Covered Dependent, or a person acting on your or his or her behalf, do not provide the notice to the Benefits Department within the time limit explained above, the maximum period for Continuation Coverage will not be extended beyond the original 18-month coverage period.

► **MEDICARE-ELIGIBLE EMPLOYEES**

If you become entitled to Medicare (Part A or B) while you are still employed by the District (but not more than 18 months before the Qualifying Event) and you then lose your health coverage because of a Qualifying Event that is a termination or reduction in your hours of employment, you can elect to have both COBRA Continuation Coverage and Medicare coverage at the same time. It may be more beneficial to purchase a Medicare supplemental contract instead of COBRA Continuation Coverage. After the Qualifying Event, your COBRA Continuation Coverage will be secondary to Medicare with respect to services or supplies that are covered, or would be covered upon proper application, under Parts A or B of Medicare.

If you think you will need both Medicare and COBRA after your retirement, you should enroll in Medicare on or before the date on which you elect COBRA Continuation Coverage. If you do not enroll in Medicare on or before the date on which you elect COBRA Continuation Coverage, your COBRA benefits will end when your Medicare coverage begins. Your Covered Dependents, however, will remain eligible for COBRA Continuation Coverage.

► COVERED DEPENDENTS OF MEDICARE-ELIGIBLE EMPLOYEES

If you become entitled to Medicare (Part A or B) while you are still employed by the District (but not more than 18 months before the Qualifying Event) and you then lose your health coverage because of a Qualifying Event that is a termination or reduction in your hours of employment, then your Covered Dependents may elect COBRA Continuation Coverage for the balance of the 36-month period starting when you became entitled to Medicare, or 18 months from your later termination or reduction in hours of employment, whichever period is longer.

You or your Covered Dependents, or a person acting on your or their behalf must provide notice of your entitlement to Medicare benefits (under Part A, Part B or both) within the time limit and in the manner described above for second Qualifying Events.

► DISABLED INDIVIDUALS

When the Qualifying Event for COBRA Continuation Coverage is your termination of employment or the reduction in your hours of employment, the 18-month period of COBRA Continuation Coverage is extended by an additional 11 months (to a total of 29 months) if these two conditions are met:

- The Social Security Administration determines that a Qualified Beneficiary (you or a Covered Dependent) is disabled, and that the date the Qualified Beneficiary's disability began was either:
 - within the first 60 days of Continuation Coverage (in the case of a Child born to or placed for adoption with you and your Spouse, the 60-day period is measured from the date of birth or placement for adoption); or
 - before the Qualifying Event and the Social Security Administration considers that the Qualifying Beneficiary remains disabled as of the date of the Qualifying Event.
- You or a Covered Dependent, or a person acting on your or his or her behalf, provide written notice to the Benefits Department of the Social Security Administration's disability determination before the end of the original 18-month period of Continuation Coverage and **within 60 days** after the latest of:
 - the date of the disability determination by the Social Security Administration;
 - the date on which the Qualifying Event occurred;
 - the date on which you or a Covered Dependent loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
 - the date on which you or a Covered Dependent are informed, through receipt of this document or an initial notice of COBRA Continuation Coverage, of both your obligation to provide the notice of the Qualifying Event and the Plan's procedures for providing such notice to the Benefits Department.

The written notice to the Benefits Department must include:

- the name of the employee or former employee who is or was a Plan participant;
- a copy of the Social Security Administration's disability determination;
- the date of that determination; and
- the name(s), address(es) and Social Security number(s) of the Qualified Beneficiaries on whose behalf Continuation Coverage is to be extended.

The timely provision of the notice by one individual will satisfy the notice requirement on behalf of all related Qualified Beneficiaries with respect to the extension of Continuation Coverage. If you or a Covered Dependent, or a person acting on your or his or her behalf, do not provide the notice to the Benefits Department within the time limit explained above, the maximum period for Continuation Coverage will not be extended beyond the original 18-month coverage period.

Continuation Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, *etc.* You, a Covered Dependent, or another person acting on your or his or her behalf, must notify the Benefits Department within 30 days of the date you are finally determined not to be disabled under the Social Security Act, if such a determination is made.

The 11-month disability extension of COBRA Continuation Coverage will end on the first day of the month following the date the Qualified Beneficiary is determined not to be disabled. Continuation Coverage due to the initial employment-related Qualifying Event, or any subsequent Qualifying Event, may still be available if the maximum period for such Continuation Coverage has not expired as of the date a determination of "no longer disabled" is made. The cost of Continuation Coverage for the 11-month disability extension will, however, increase after the 18th month of Continuation Coverage, unless coverage would continue in any event on account of a second Qualifying Event. The increase, if any, will not exceed 150 percent of the cost to the Plan, including both employer and employee contributions, for coverage of a similarly situated Medical or Dental Benefit Program or EAP participant (as applicable) or beneficiary who is not receiving Continuation Coverage.

► SPECIAL RULES FOR THE UHCRA BENEFIT PROGRAM

The COBRA Continuation Coverage you may elect with respect to the UHCRA Benefit Program is different from the Continuation Coverage you may elect with respect to the Medical, Dental and Vision Benefit Programs and the EAP.

First, Continuation Coverage for the UHCRA Benefit Program is only available until the end of the Plan Year in which the Qualifying Event occurs and not for 18, 29 or 36 months as for Medical, Dental, and Vision Benefit Program Continuation Coverage. To receive Continuation Coverage you must pay the applicable premium, and the District is entitled to add a two percent administration charge. The benefits under the UHCRA Benefit Program involve reducing your compensation, and paying medical expenses on a pre-tax basis. You may be eligible for

COBRA Continuation Coverage under the UHCRA Benefit Program, but you would have to pay for the coverage on an after-tax basis (plus the two percent administrative fee).

Second, the District does not have to offer you COBRA Continuation Coverage for the UHCRA Benefit Program if, at the time of the Qualifying Event, the premium you must pay for this coverage exceeds the remaining coverage available to you for the Plan Year under the UHCRA Benefit Program. For example, if you terminate employment in March after electing to contribute \$1,800 to the UHCRA Benefit Program and you have already submitted claims totaling \$1,000, then your remaining coverage would be \$800, but your cost to keep this coverage would be \$1,377 ($\$1,800 \times 102\% = \$1,836/12 = \$153/\text{month}$ times the nine months remaining in Plan Year). In this case, you would ***not*** be entitled to Continuation Coverage under the UHCRA Benefit Program. Before electing Continuation Coverage under the UHCRA Benefit Program, you should contact the Benefits Department and evaluate your alternatives.

► **TRADE ACT**

If you should lose your job, and, as a consequence, are eligible for trade adjustment assistance under the Trade Act of 2002, or if you are at least age 55 and receiving a pension benefit from the Pension Benefit Guaranty Corporation, you may be eligible to take a tax credit or get advance payment of up to 65 percent of your COBRA Continuation Coverage premiums. In certain circumstances, you may also be eligible for a second 60-day COBRA Continuation Coverage election period. If you have questions about these Trade Act provisions, you may contact the Health Care Tax Credit Customer Contact Center toll-free at 866.628.4282 or 866.626.4282 (TTD/TTY). More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

► **QUESTIONS ABOUT COBRA CONTINUATION COVERAGE**

If you are an active employee or a COBRA participant and you have questions about COBRA Continuation Coverage, you may contact the Benefits Department. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act of 1996 (“**HIPAA**”), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration in your area or visit its website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District Employee Benefits Security Administration offices are available through its website.

► **KEEP THE PLAN INFORMED OF ADDRESS CHANGES**

In order to protect your family’s rights, you should keep the Benefits Department informed of any changes in the addresses of family members. You should also keep copies, for your records, of any notices you send to the Benefits Department.

MILITARY LEAVE CONTINUATION COVERAGE

If you are absent from work because you are voluntarily or involuntarily on Active Duty in the Uniformed Services you have the right under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (“**USERRA**”) to elect up to 24 months of continuation coverage for you and your Covered Dependents under the Plan's Medical, Dental and Vision Benefit Programs and the EAP. You may also continue coverage under the UHCRA Benefit Program through the end of the Plan Year in which you started your qualified military leave.

► ELIGIBILITY

“**Active Duty**” includes duty for training, including training for service in a Reserve unit, initial active duty for training, inactive duty training, full time National Guard duty and any absence needed for an examination to determine whether you are fit to perform military duty. “**Uniformed Services**” includes duty in the Army, Air Force, Marine Corps, Coast Guard and their reserves, or the Army and Air National Guards, and the Public Health Service commissioned corps, as well as service or authorized training as an intermittent disaster-response appointee upon activation of the National Disaster Medical System.

Your Eligible Dependents who are participants in the Plan immediately before the date of your qualified military leave of absence are eligible to elect continuation coverage under USERRA as well.

► PARTICIPATION

If you or your Eligible Dependents wish to continue participation in the Medical, Dental, Vision and UHCRA Benefit Programs during your Military Leave, you must make arrangements with the Benefits Department to pay for the coverage you and your Eligible Dependents wish to maintain. You can pay your Benefit Contributions:

- in advance of your leave with after-tax payments, or
- during your leave by sending a check monthly to the Benefits Department.

If you do not make arrangements with the Benefits Department prior to your leave, benefits under the Medical, Dental, Vision and UHCRA Benefit Programs will end the date you start your military leave.

► PREMIUM PAYMENT

If you elect continuation coverage under USERRA, you or your Covered Dependent are responsible for the cost of this coverage after a period of time. If you are absent from work due to Active Duty for a period not longer than 12 weeks, the cost of the coverage will be the amount charged to active employees for the same coverage. For absences exceeding 12 weeks, the cost will be up to 102 percent of the total cost of coverage under the Plan, which includes your share

of the cost of coverage and any portion previously paid by the District, as well as a two percent administrative fee.

► DURATION OF COVERAGE

If you elect continuation coverage under USERRA, you have the right to continue coverage until the earlier of:

- 24 months beginning the first day of absence from employment due to service in the Uniformed Services; or
- the day after you fail to apply for or return to employment as required by USERRA after you have completed a period of duty with the Uniformed Services.

Generally, to be eligible for the rights guaranteed by USERRA, you must:

- return to work on the first full, regularly scheduled work day following your period of Active Duty, safe transport home, and eight-hour rest period if you are on military leave for less than 31 days;
- return to or reapply for reemployment within 14 days of completion of your period of Active Duty, if your absence from employment is from 31 to 180 days; or
- return to or reapply for reemployment within 90 days of completion of your period of Active Duty, if your military service lasts more than 180 days.

Under Federal law, the period of coverage available to you and your Covered Dependents under USERRA runs concurrently with any continuation coverage available under COBRA. Eligibility for TRICARE or active duty military coverage will not terminate USERRA continuation coverage.

Your participation in the LTD and Life/AD&D Benefit Programs may continue for 12 weeks following the date you start your military leave (subject to the terms of the Benefit Programs, including any exclusions or limitations). For the DFSA Benefit Program, your participation will end on the date you start your military leave. If your participation in any of the Benefit Programs ends during your leave for Active Duty, you may resume participation in these Benefit Programs on the date you timely return to employment at the end of your qualified military leave.

HIPAA PRIVACY AND SECURITY RULES

HIPAA, the Standards for Privacy of Individually Identifiable Health Information (the “**Privacy Rule**”) and the Health Insurance Reform: Security Standards (“**Security Rule**”) require the Plan to protect the confidentiality of your Protected Health Information and the security of your Electronic Protected Health Information that it obtains about you or your Covered Dependents in the course of providing Plan health care benefits. The Privacy Rule applies to the Plan’s Medical, Dental, and Vision and UHCRA Benefit Programs and the EAP. The Plan has also required its service providers that create, receive, or maintain your Protected Health Information (“**Business Associates**”) to agree to protect your Protected Health Information and secure your Electronic Protected Health Information.

Under the Privacy Rule, the Plan may use and disclose your Protected Health Information as permitted or required by the Privacy Rule, as described in this document, or when you authorize the use or disclosure. “**Protected Health Information**” or “**PHI**” includes any information, whether oral or recorded, in any form or medium that is created or received by the Plan that relates to your past, present or future physical or mental health, including the provision of and payment for care, that identifies you or provides a reasonable basis for your identification. PHI includes ePHI. PHI does not include de-identified health information or health information that the District is entitled to under applicable law (for example, FMLA, Americans with Disabilities Act, Occupational Safety and Health Act, workers’ compensation laws and other state and federal laws), or health information that the District obtains through sources other than the Plan and retains as part of your employment records (*for example*, drug screening tests, fitness for duty examination results or other types of similar information). This type of information, therefore, is not subject to the Privacy Rule, nor the restrictions described in this document. “**Electronic Protected Health Information**” or “**ePHI**” means PHI stored, maintained or transmitted electronically.

As part of its efforts to comply with the HIPAA Privacy Rule and the Security Rule, the Plan has appointed a Privacy Official and a Security Official. The Privacy Official is the person with whom you should lodge any complaints if you believe that the confidentiality of your or your Covered Dependent’s PHI has been compromised in the course of administering your benefit Claims. The Security Official is the person who has the authority to make policies and procedures and to perform other functions necessary to comply with the Security Rule. You should report a breach of security of your ePHI to the Security Official. The “**Privacy Official**” for the Plan is the Plymouth-Canton Community Schools Director of Integrated Technology Systems, Jim Casteel.

► **REQUIRED DISCLOSURES OF PHI BY THE PLAN**

The Plan must disclose your PHI:

- to you, with respect to your own PHI;
- to the Secretary of the United States Department of Health and Human Services to determine whether the Plan is in compliance with the Privacy Rule; or

- where required by law (this means that the Plan will make the disclosure only when the law requires it to do so, but not if the law would just allow it to do so).

► **PERMITTED USES AND DISCLOSURES OF PHI BY THE PLAN**

The Plan may use or disclose your PHI as necessary for the operation of the Plan as described in this document and under the following conditions:

- to you with respect to your own PHI;
- for treatment purposes, when necessary;
- to carry out Payment and Health Care Operations;
- to the Plan’s Workforce;
- to Business Associates that enter into Business Associate agreements with the Plan;
- under certain circumstances expressly permitted by the Privacy Rule;
- to you about treatment alternatives or other health-related benefits or services that may be of interest to you; or
- with a proper authorization received from you.

Even if a use or disclosure of PHI is permitted above, the Plan will comply with any special protections under state or federal law that are more protective of your privacy.

Payment and Health Care Operations

The Plan may use or disclose your PHI for Payment purposes. “**Payment**” includes activities undertaken by the Plan to obtain Benefit Contributions or to determine and fulfill its responsibilities for providing benefits under the Plan’s Medical, Dental, Vision and UHCRA Benefit Programs and the EAP, including:

- determinations of eligibility or coverage, including coordination of benefits with other health plans;
- disclosure to physicians of your eligibility for coverage and the percentage or amount of the bill the Plan might pay;
- adjudication or subrogation of health benefit Claims;
- risk adjusting amounts due based on enrollee health status and demographic characteristics;

- billing, Claims management, collection activities;
- obtaining payment under a contract of reinsurance, including stop-loss or excess loss insurance whether obtained with respect to the direct payment obligation of the Plan or the indirect contribution obligation of the District for benefits under the Plan (and related health care data processing);
- review of health care services with respect to medical necessity, coverage under the Plan, appropriateness of care, and justification of charges;
- utilization review activities, including pre-certification and pre-authorization, concurrent and retrospective review;
- disclosure to consumer reporting agencies of only the following items related to the collection of Benefit Contributions or reimbursements:
 - your name and address,
 - your date of birth,
 - your Social Security number,
 - your payment history,
 - your account number (if any), and
 - the name and address of your health care provider and/or this Plan.

The Plan may also use or disclose your PHI for Health Care Operations. “**Health Care Operations**” cover a wide range of activities, including:

- quality assessment activities;
- reviewing the qualifications of health care professionals;
- underwriting, premium writing and other activities relating to creating, obtaining, or renewing health insurance or health benefits, including a contract of reinsurance or stop-loss insurance obtained in connection with the provision of Plan benefits, either directly or indirectly;
- conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse detection and any required compliance programs;
- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including but not limited to formulary development and administration, development or improvement of methods of payment or providing benefits;
- creating de-identified information or limited data sets, if needed, for Plan administration; and

- business management and general administrative activities of the Plan, including providing data analysis of Plan costs to the District.

Uses and Disclosures of PHI Expressly Permitted by the Privacy Rule

The Privacy Rule permits the Plan to use or disclose your PHI as follows:

- as required by law (that means the state or federal law requires, and does not merely permit, the Plan to make the disclosure);
- for public health purposes;
- to report information about victims of abuse, neglect or domestic violence;
- for health oversight activities;
- for judicial and administrative proceedings pursuant to judicial or administrative orders or where the Plan has received adequate assurances (as provided in the Privacy Rule), that the PHI to be disclosed will remain confidential;
- to your personal representative, after receiving proof that he or she may act on your behalf;
- to individuals involved with your care or payment for your care, if the Plan provides you with the opportunity to object and you do not, or the Plan infers from the circumstances that you do not object;
- for certain law enforcement purposes as set forth in the Privacy Rule;
- to correctional facilities regarding inmates;
- to report information about decedents to funeral directors, coroners and medical examiners;
- for purposes of cadaveric organ, eye or tissue donation;
- for use in a limited data set for purposes of research, public health or Health Care Operations, if a data use agreement has been signed;
- for research purposes;
- to avert a serious threat to health or safety;
- for emergencies and disaster relief;
- for specialized governmental functions (*for example*, national security or defense);

- incidental disclosures, provided the Plan puts reasonable physical safeguards in place; and
- for workers' compensation.

► **DISCLOSURE OF PHI BY THE PLAN TO THE DISTRICT**

The Plan may disclose your PHI to the District to carry out Plan administrative functions because the District agrees to the following provisions. These disclosures, however, will only be made to the Plan's Workforce. The District agrees to:

- not use or further disclose the information other than as permitted or required as explained in this document, or as required by law;
- ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the District with respect to such information and agree to implement reasonable and appropriate security measures to protect ePHI;
- 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 District, except the District may make disclosures with respect to workers' compensation as described above;
- report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided under the Plan of which it becomes aware;
- report to the Plan any security incident of which it becomes aware;
- make available to you your PHI that is maintained by the Plan and provide you with the right to obtain a copy of your PHI disclosed to and retained by the District;
- permit you to amend your PHI maintained by the Plan and incorporate these amendments as required by the Privacy Rule;
- permit you to have an accounting of the disclosures of your PHI made by the Plan, as described in the following section titled, "Your Rights Under HIPAA and the Privacy Rule";
- make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the United States Department of Health and Human Services for purposes of determining compliance with the Privacy Rule and Security Rule;
- if feasible, return or destroy all PHI received from the Plan that the District still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that if such return

or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

- ensure that adequate separation between the Plan and the District is established as described below and support this separation with reasonable and appropriate security measures; and
- implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of ePHI.

The Plan and the District will take steps to provide for the adequate separation between the Plan and the District. Only those employees of the District identified in Appendix D as the Plan's Workforce will have access to your PHI. The Plan's Workforce will receive PHI, as needed in the ordinary course of business, to carry out the Payment, Health Care Operations or other functions necessary for the proper operation of the Plan. The Plan will restrict the access to, and use and disclosure of, your PHI by these employees to those administrative functions that the District performs for the Plan. The Plan may also disclose limited health information to the Plan's Workforce in connection with enrollment or disenrollment of individuals into or out of the Plan. The District will handle any complaint relating to Plan Workforce noncompliance by addressing that issue with the employee. The District will also provide a mechanism for resolving issues of noncompliance, including disciplinary action up to and including discharge.

The employees listed in Appendix D are responsible for carrying out Plan administrative functions on behalf of the District and are entitled to receive and create PHI about you and your Eligible Dependents in the course of carrying out their administrative duties for the Plan ("**Plan's Workforce**"). To maintain the confidentiality of your PHI, you should only communicate with the Benefits Department if you wish to inquire about any aspect of the Plan, a benefit Claim, your entitlement to coverage or any other matter regarding the Medical, Dental, Vision and UHCRA Benefit Programs and the EAP. Your local Managers only have access to your enrollment information so you should not share your PHI with them.

The Plan's Workforce has been trained to protect and secure any PHI communicated to them by you, your close family members, your health care provider, an insurer, or any entity that has been engaged to carry out any activities on their behalf with respect to the payment of your covered benefits. Specifically, any PHI that these individuals may learn about you or your family in the course of administering the Plan will not be provided to the District for any employment-related purpose or for the administration of any other Benefit Program sponsored and maintained by the District, without your express authorization.

► YOUR RIGHTS UNDER HIPAA AND THE PRIVACY RULE

You have certain rights, under HIPAA and the Privacy Rule, relating to your PHI maintained by the Plan, including the right to:

- access and copy your PHI;

- receive an accounting of disclosures of PHI made within a six-year period just before your request, other than those made:
 - for purposes of treatment, Payment and Health Care Operations,
 - before April 14, 2003,
 - to you or close family members involved in your care,
 - to law enforcement officers, correctional institutions (about inmates) or for national security purposes,
 - incidentally to otherwise permitted disclosures,
 - as part of a limited data set, and
 - with your express authorization;
- amend your PHI, under certain circumstances;
- request restrictions on the permitted uses and disclosures of your PHI;
- request confidential communications (for example, sending information to an alternate address);
- file a complaint with the Plan's Privacy Official, the person named in an insurer or HMO's Notice of Privacy Practices to receive complaints, or with the Secretary of the United States Department of Health and Human Services if you believe your rights have been violated (the Privacy Official will investigate all complaints and remedy any incidents of non-compliance in accordance with the Plan's Privacy Policies and Procedures); and
- receive a copy of the Plan's Notice of Privacy Practices.

All requests to exercise your individual rights must be made in writing to the Privacy Official. The Plan's Claims Administrators keep their own records and you must make any requests relating to your PHI in those records directly to the Claims Administrator. The Plan's Notice of Privacy Practices, which was provided to you, contains a more detailed description of the Plan's privacy procedures and your rights under HIPAA. Contact the Benefits Department for more information or to receive a copy of the Notice of Privacy Practices.

If you have questions about the status of your PHI or what is being done to protect its confidentiality, or if you wish to file a complaint or exercise any of your individual rights, please contact the Privacy Official.

COORDINATION OF BENEFITS

Insured benefits under the insured Benefit Programs will be coordinated with the applicable provision of the policies and Booklets provided by the Claims Administrators. **With respect to the Self-funded Benefit Programs, the Plan will coordinate as described in this section.**

Coordination will be made with, among others:

- another group health plan (including any employer sponsored welfare benefit plan, whether or not insured, which provides medical, prescription drug, or dental coverage, such as insurance provided by a Spouse's employer); and
- money you, your Spouse, or other Covered Dependent could receive from another person or entity who caused the injuries on account of which a claim was made.

When the Plan coordinates benefits, one source of benefits will be "**Primary**" (that is, it will pay before the other source). The other source will be "**Secondary**" (that is, it will pay after the source of benefits that is Primary).

When the Plan is Primary, it will pay benefits as if there were no other source of benefits. But if the Plan is Secondary, it will first calculate what it would pay in the absence of any other source of benefits. The Plan will then subtract from that amount the amount that should be paid by the other source. The Plan will pay that difference, so that you or your Covered Dependent will receive the full amount of benefits payable under the Plan. (The amount payable by the other source will be subtracted even if you do not apply for benefits from that other source.) The Plan will not, however, pay more than it would have if it were the only source of benefits.

Benefits will be paid as follows:

First: A plan without a coordination of benefits provision will pay.

Second: A plan that covers a person as an employee pays first. A plan that covers a person as a dependent pays second.

Third: In the case of a patient who is a dependent and a minor Child who is covered under both plans of parents who are not divorced or legally separated, the plan that covers the parent (or legal guardian) whose birthday occurs earlier in the year will pay first. If the birthdays are the same, the plan covering the dependent for the longest period of time will pay first.

Fourth: In the case of a patient who is a dependent and a minor Child of divorced or legally separated parents:

- If a Qualified Medical Child Support Order, or a divorce decree or separation agreement makes a parent responsible for a Child's health expenses, that parent's plan (that also covers the Child) will pay.
- Then a plan that covers the Child as a dependent of a custodial parent will pay.
- Then a plan that covers the Child as a dependent of the Spouse of the custodial parent will pay.
- Then a plan that covers the Child as a dependent of the non-custodial parent will pay.

Fifth: The plan that has covered the patient for the longer period of time will pay.

Sixth: Any other plan will pay.

If two or more plans have the same priority, they will each pay *pro-rata*.

► SPECIAL RULES

There are some special rules, however, which have precedence over the above priorities. They are:

- COBRA Continuation Coverage is always Secondary to any other group health plan.
- Coverage provided by virtue of being a retired or laid-off employee or an employee on a leave of absence is always Secondary to coverage provided by virtue of that individual being an active employee.

► COORDINATION WITH MEDICARE

The general rule is that the Plan will be Secondary to Medicare in all circumstances where federal law does not require the Plan to be Primary. If you are covered under the Plan as an active employee and you or your Spouse are over 65 years old and eligible for Medicare, you may reject coverage in this Plan and rely on Medicare as your sole source of coverage. If you do not reject coverage under this Plan, you will have coverage under both this Plan and Medicare, and Medicare will be Secondary.

Medicare is also available for certain people who have not yet reached the age of 65, but who have received Social Security Disability benefits for 24 months. When Medicare is available in those situations, the Plan will be Primary for you and your Covered Dependents as long as you are in current employment status; otherwise the Plan will be Secondary.

Medicare is also available to individuals who have been under treatment for end-stage renal disease. The Plan will be Secondary to Medicare for a covered individual who qualifies for Medicare benefits because of end-stage renal disease to the extent permitted by law.

It is your responsibility to apply for Medicare benefits that are available. If Medicare is Primary under these rules, the Plan will calculate the benefits it provides as if you were enrolled in Medicare, regardless of whether you have applied.

► **COORDINATION WITH MOTOR VEHICLE ACCIDENT INSURANCE**

The Plan's liability for expenses arising out of a motor vehicle accident is based on the type of motor vehicle insurance law enacted by your state. Currently there are three types of state motor vehicle insurance laws:

- no-fault motor vehicle insurance laws;
- financial responsibility laws; and
- other motor vehicle liability insurance laws.

If you do not have motor vehicle insurance coverage even though you are legally required to do so, the Plan will not pay any medical expenses arising out of motor vehicle accidents in which you are involved.

Coordination Under No-Fault Motor Vehicle Insurance Laws

The Plan intends to coordinate payment of its benefits on a Secondary basis. This means that if you purchase a motor vehicle insurance policy which makes "other health coverage" Primary, the Plan will still pay Secondary. Also, if you purchase a standard policy under which the motor vehicle insurer will pay Primary, then the Plan will pay Secondary. This Plan does not provide coverage for medical expenses covered by a motor vehicle accident that are otherwise covered by a no-fault motor vehicle insurance policy.

For accidents where another state's insurance laws are determinative, if the relevant state's no-fault act does not provide for a policy alternative whereby motor vehicle coverage can be made Secondary, nor mandates that the motor vehicle insurer pay Secondary, it is the general intent of the Plan to pay Secondary for medical expenses arising out of motor vehicle accidents.

You are considered covered under a motor vehicle insurance policy if you are:

- an owner or principal named insured under the policy;
- a family member of a person insured under the policy; or
- a person who would be eligible for medical expense benefits under a motor vehicle insurance policy if this Plan did not exist.

Coordination Under Financial Responsibility Law

If, however, the state has a “financial responsibility” law that does not allow the Plan to be Secondary, or that does not allow the Plan to subrogate or recover its payments, the Plan will pay any benefits related to a motor vehicle accident on a Primary basis.

Coordination Under Other Motor Vehicle Liability Insurance

If the state does not have a no-fault motor vehicle insurance law, nor a “financial responsibility” law, the Plan is Secondary to motor vehicle insurance coverage or to any other person or entity who caused the accidents or who may be liable for your medical expenses or lost wages pursuant to the general rule for “Coordination with Third Parties” set forth below.

► COORDINATION WITH THIRD PARTIES

If a third party negligently or tortiously causes a health problem on account of which you have Incurred medical expenses, the Plan is Secondary to the third party’s liability to you. If benefits are available under any insurance policy as a result of this negligent or tortious conduct, the Plan is Secondary to those benefits.

► FACILITY OF PAYMENT

If an expense or benefit that should have been paid by the Plan is paid by another person or entity, the Plan may pay to that person or entity any amount that it considers necessary to satisfy the intent of the Plan’s coordination provisions. The Plan will then have no further liability for those expenses or benefits.

SUBROGATION/RIGHT OF RECOVERY

The subrogation rights and rights of recovery with respect to the insured Benefit Programs are explained in the applicable provisions of the various insurance policies and Booklets provided by the insurance companies. For all the Self-funded Benefit Programs under the Plan, the subrogation/right of recovery provisions below apply.

The Plan is designed to pay only those expenses for which payment is not available from another source, including any insurance District, group health plan, or individual. The Plan may pay covered expenses that may be, or may become, the responsibility of another person, however the Plan is entitled to receive reimbursement for those payments. The Plan has no obligation to pay expenses that may be the responsibility of another person.

By enrolling in the Plan and applying for benefits from the Plan, you and your Covered Dependents are subject to, and agree to be bound by, the following terms and conditions.

► ASSIGNMENT OF RIGHTS (SUBROGATION)

By accepting benefits from this Plan, you and your Covered Dependents automatically assign to the Plan any rights you or they may have to recover all or part of the same covered

expenses from another source, including another group health plan, insurer or individual, limited, however, to the amount of covered expenses the Plan has paid on behalf of you and/or your Covered Dependents. This assignment also grants the Plan a right to recover from your no-fault auto insurance carrier in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage. By virtue of the assignment, the Plan is entitled to recover 100 percent of the covered expenses it has paid on behalf of you or your Covered Dependents from all recoveries from a third party (whether by lawsuit, settlement or otherwise).

This assignment allows the Plan to pursue any Claim that you may have against a third party, or its insurer, whether or not you choose to pursue that Claim. This assignment also includes, without limitation, the assignment to the Plan of a right to any funds paid by a third party to you or your Covered Dependents, or paid on behalf of you or your Covered Dependents. This assignment entitles the Plan to be reimbursed on a first-dollar basis (that means the Plan will have a first priority claim to the Recovered Funds), whether the funds paid to or for the benefit of you and/or your Covered Dependents amounts to a full or partial recovery, or whether the funds paid are designated for non-medical charges, attorneys' fees, or other costs and expenses. The Plan's share of the recovery will not be reduced because you or your Covered Dependent has not received the full damages claimed, unless the Plan agrees in writing to a reduction.

When you, and not the Plan, pursue and obtain any recovery, you shall be responsible for all expenses involved in obtaining that recovery from any third party payer, whether by settlement or judgment, including but not limited to all attorneys' fees, costs, and expenses; which fees, costs, and expenses shall not reduce the amount that you or your Covered Dependents are required to reimburse the Plan.

► **EQUITABLE LIEN AND OTHER EQUITABLE REMEDIES**

The Plan has an equitable lien against any money or property you or your Covered Dependents recover from any party, including an insurer, another group health plan or individual, but only to the extent of the covered expenses that the Plan has paid. This equitable lien also attaches to any payment received from workers' compensation, whether by judgment or settlement, where the Plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers will be deemed to mean that such a determination has been made. This equitable lien also attaches to any money or property obtained by anybody (including, but not limited to you, your Covered Dependents, your or their attorney, any individual entitled to receive any recovered amounts on your or your Covered Dependent's behalf, and/or a trust established on behalf of the individual) that is received as a result of the individual exercising his or her rights of recovery ("**Recovered Funds**"). The Plan is also entitled to seek any other equitable remedy against any party possessing or controlling any Recovered Funds.

This and any other provisions of the Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA and relevant case law. The Plan's provisions concerning subrogation, equitable liens, and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

► OBLIGATION TO ASSIST IN THE PLAN'S REIMBURSEMENT ACTIVITIES

If you are involved in an automobile accident, or suffer an illness or injury that may entitle you to recover from a third party, and the Plan advances payment, you and your Covered Dependents have an obligation to help the Plan obtain reimbursement for the amount of the payments it advanced for which another source was also responsible for making payment. As part of this obligation, you and your Covered Dependents are required to provide the Plan with any information concerning any other applicable insurance coverage that may be available (including, but not limited to, automobile, home, and other liability insurance coverage, and coverage under another group health plan), and the identity of any other person or entity, and their insurers (if known), that may be obligated to provide payments or benefits on account of the same illness or injury for which the Plan made payments. You and your Covered Dependents are required to:

- cooperate fully in the Plan's exercise of its right to subrogation and reimbursement;
- not do anything to prejudice those rights (such as settling a claim against another party without notifying the Plan or by not including the Plan as a co-payee);
- sign any document deemed by the Plan Administrator to be relevant in protecting the Plan's subrogation and reimbursement rights; and
- provide relevant information when requested.

The term "information" here includes any documents, insurance policies, and police or other investigative reports, as well as any other facts that may reasonably be requested to help the Plan enforce its rights. Failure by you or your Covered Dependents to cooperate with the Plan in the exercise of these rights may result, at the discretion of the Plan Administrator in a reduction of future benefit payments available to you or your Covered Dependents under the Plan by an amount, up to the aggregate amount paid by the Plan that was subject to the Plan's equitable lien, but for which the Plan was not reimbursed.

► PAYMENTS BY OTHER SOURCES

The Plan will not pay any expense or benefit that has actually been paid by another source, even if that other source is Secondary to the Plan, unless that source files a claim for reimbursement. If the other source files a claim for reimbursement, the Plan's Facility of Payment provision applies.

PRE-TAX PAYMENT BENEFIT PROGRAM

The District may require you to contribute or pay for some or all of the benefits under the Plan's Benefits Programs. These contributions are called "**Benefit Contributions.**" The Pre-Tax Payment Benefit Program gives you an opportunity to make your Benefit Contributions for some Benefit Programs on a *pre-tax basis*, so that your contributions will *not* be subject to federal, state, or most municipal income taxes or Social Security taxes. The Pre-Tax Payment Program is intended to qualify as a cafeteria plan under Section 125 of the Code.

Some Benefit Contributions, however, cannot be made on a pre-tax basis under the Pre-Tax Payment Benefit Program and you must make the Benefit Contributions on an after-tax basis. Appendix A lists the Benefit Programs for which Benefit Contributions can be made on a pre-tax basis through the Pre-Tax Payment Benefit Program.

You can participate in the Pre-Tax Payment Benefit Program only if you are eligible for a Benefit Program that has pre-tax Benefit Contributions.

► HOW THE PRE-TAX PAYMENT BENEFIT PROGRAM WORKS

Under the Pre-Tax Payment Benefit Program, a portion of your taxable compensation is reduced and applied by the District to make the **Benefit Contributions** to the Plan *on a pre-tax basis*. Because your compensation is reduced, however, participation in the Pre-Tax Payment Benefit Program may reduce other benefits which are based on your compensation (such as Social Security, life insurance, and disability insurance). For most employees, these benefit reductions are fairly small, particularly compared to the tax savings. In some cases, benefits might not be reduced at all.

► REDUCTION OF COMPENSATION

The amount by which the District will reduce your compensation to make your Benefit Contributions will be stated in the Enrollment Form or other materials provided to you. The District will set the Benefit Contributions and communicate them to you during the Open Enrollment Period for each Plan Year. (The materials listing the amount of the Benefit Contributions are considered part of this SPD/Plan document.)

► TREATMENT OF BENEFIT CONTRIBUTIONS WHILE ON LEAVE

If you take an unpaid leave of absence, you will not be able to participate in the Pre-Tax Payment Benefit Program during your leave. If you remain eligible to continue your participation in the other Benefit Programs during your unpaid leave, you will need to make your Benefit Contributions on an after-tax basis, unless you choose to make-up your Benefit Contributions when you return from your leave of absence in the same Plan Year. If you choose to make-up your Benefit Contribution when you return from your leave of absence in the same Plan Year, you may make those Benefit Contributions on a pre-tax basis.

If you are on a paid leave (whether or not FMLA-qualified), you can continue to participate in the Pre-Tax Payment Benefit Program so long as you remain eligible to participate in the Benefit Programs that require pre-tax Benefit Contributions.

UNREIMBURSED HEALTH CARE FLEXIBLE SPENDING ACCOUNT BENEFIT PROGRAM

The UHCRA Benefit Program is designed to help you pay for Eligible Health Care Expenses (defined below) by allowing you to pay these expenses with *pre-tax* dollars. It is intended to qualify as a cafeteria plan under Section 125 of the Code and as an accident and health plan under Section 105 of the Code. Under the Program, you may authorize *pre-tax* contributions, through paycheck deductions, to an Unreimbursed Health Care Flexible Spending Account (“**Health Care Account**”) that the District will establish for you.

Your Health Care Account will be credited each payroll period with the paycheck deduction amount you authorized. Your Health Care Account is for bookkeeping purposes only. The amounts credited to your Health Care Account can only be used to reimburse you for Eligible Health Care Expenses or those amounts will be forfeited after the end of the calendar year.

► AMOUNT THAT YOU MAY CONTRIBUTE TO YOUR HEALTH CARE ACCOUNT

You may contribute up to \$5,000 or \$3,000 (depending on your classification) each calendar year to the UHCRA Benefit Program. The minimum amount you may contribute to your Health Care Account annually is \$100.00. If you start participating in the UHCRA Benefit Program after the calendar year has begun, the amount you may contribute to the Plan will be *pro rated* based upon the number of months remaining in the calendar year. In some circumstances, the Plan Administrator may reduce the amount you may contribute in order to comply with requirements under the Code.

► AMOUNT THAT CAN BE REIMBURSED TO YOU

The amounts credited to the UHCRA Benefit Program for you may only be used to pay for your, or an Eligible Dependent’s Eligible Health Care Expenses Incurred while you were covered under the UHCRA Benefit Program. An expense is “**Incurred**” on the date that the service, which gives rise to the expense, is rendered. If you are not sure whether an expense qualifies for health care reimbursement, you should contact the Claims Administrator listed in Appendix B.

Immediately upon your participation in the UHCRA Benefit Program, the full value of the amount you have elected to contribute for the year will be available to reimburse you for Eligible Health Care Expenses.

► ELIGIBLE HEALTH CARE EXPENSES

“**Eligible Health Care Expenses**” are for medical care, as defined in Code Section 213(d) (except for health insurance premiums or qualified long term care expenses), for you and your Eligible Dependents for which you have not been reimbursed through insurance or any other source. Generally, Eligible Health Care Expenses are Incurred for the diagnosis, cure, mitigation, treatment or prevention of disease.

For example, Eligible Health Care Expenses include amounts paid for:

- hospital bills;
- doctor, dental, or eye care bills;
- prescription drugs and over-the-counter medications or drugs purchased for the treatment of medical conditions; and
- insurance deductibles and copayments that are not reimbursed by another insurance plan or reimbursement account.

► INELIGIBLE HEALTH CARE EXPENSES

“**Ineligible Health Care Expenses**” *do not* qualify for reimbursement under the UHCRA Benefit Program and include:

- expenses paid on behalf of an individual who is not an Eligible Dependent;
- expenses that are payable under any other insurance plan or group health plan (including one sponsored by the District) or that were paid under another employer’s health care spending account program (at the Plan Administrator’s request, you are obligated to supply additional information sufficient for the Plan Administrator to determine the existence of any duplications of Claims payments);
- expenses for which you have received, or will receive, an itemized deduction on your federal tax return;
- expenses for premiums for insurance not provided by your employer (for example, premiums paid for your Spouse’s insurance);
- expenses in excess of the annualized elected amount;
- expenses Incurred during a time you were not covered by the UHCRA Program;
- expenses for which you have not provided satisfactory proof of services;
- expenses Claimed later than the March 31st following the end of the calendar year;

- expenses for over-the-counter drugs that are not for medical care (for example, vitamins or dietary supplements); and
- expenses related to elective cosmetic surgery.

Any reimbursement paid for an Ineligible Health Care Expense under the UHCRA Benefit Program will be subject to applicable income and other payroll taxes.

► **TAX ADVANTAGES OF PARTICIPATION IN THE UHCRA BENEFIT PROGRAM**

The UHCRA Benefit Program lets you pay up to \$5,000 a year in Eligible Health Care Expenses with part of your income that is withheld before it is taxed. This lowers your income that is subject to federal income and Social Security taxes, as well as state and most municipal income taxes, if any.

Example of How the UHCRA Benefit Program Saves Money:

You earn \$30,000 per year and you are in the 25% tax bracket. You estimate that your yearly Eligible Health Care Expenses will be \$1,500. So, you choose to contribute \$1,500 to your Health Care Account. Your savings will be:

	Using UHCRA Program	Not Using UHCRA Program
Your Gross Pay	\$30,000	\$30,000
Your Pre-Tax Health Care Expenses	<u>1,500</u>	<u>N/A</u>
Your Taxable Income	28,500	30,000
Your Income Taxes (25%)	7,125	7,500
Your Post-Tax Health Care Expenses	<u>0</u>	<u>1,500</u>
Your Net Take Home Pay	21,375	21,000
Your Savings	\$375	N/A

► **FEDERAL ITEMIZED DEDUCTION**

You are not entitled to receive both an itemized federal income tax deduction for medical expenses and a reimbursement under the UHCRA Benefit Program for the same expense. Before enrolling in the UHCRA Benefit Program, you should determine whether reimbursement of medical expenses under the UHCRA Benefit Program is more advantageous than the itemized federal income tax deduction. If your medical expenses never exceed 7.5% of your adjusted gross income, reimbursement under the UHCRA Benefit Program may be more advantageous. Remember, however, that the UHCRA Benefit Program will always be more advantageous for reimbursement for over-the-counter medication purchases because those purchases are not usually eligible as itemized deductions for federal income tax purposes.

► EXPENSES ELIGIBLE UNDER MORE THAN ONE HEALTH CARE REIMBURSEMENT ACCOUNT PROGRAM

If an expense is reimbursable under two or more health care reimbursement account programs, you may submit a Claim for the expenses to either program, but the UHCRA Benefit Program will not pay any expenses paid by another program. At the Claims Administrator's request, you must supply additional information sufficient for the Claims Administrator to determine if Claim payments have been duplicated.

► FORFEITURE OF AMOUNTS REMAINING AT THE END OF THE CALENDAR YEAR

If you do not use the total amount in your Health Care Account for reimbursement of Eligible Health Care Expenses Incurred during the calendar year, the amount remaining in your Account will be forfeited on the April 1st following the end of the calendar year, and will not be returned to you. Forfeited amounts will be used to pay the Plan's administrative expenses.

► TERMINATION OF THE UHCRA BENEFIT PROGRAM

In the event the UHCRA Benefit Program is terminated, any amounts in your Health Care Account will remain available for 90 calendar days after the Program's termination date for reimbursement of Eligible Health Care Expenses that were Incurred while the UHCRA Benefit Program was in effect (and limited to the current calendar year).

► MAKING CONTRIBUTIONS DURING FMLA LEAVE OF ABSENCE

If Your FMLA Leave of Absence is Paid

If you are taking a paid leave of absence, you will continue making contributions to your Health Care Account on a pre-tax basis pursuant to your Enrollment Form. In this case, your participation in the UHCRA Program will continue as if you had never left your employment and healthcare expenses Incurred during the period of your leave will be eligible for reimbursement.

If Your FMLA Leave of Absence is Unpaid

If you take an unpaid leave of absence, you have the following choices:

- ***End your participation in the UHCRA Benefit Program and discontinue making contributions to your Health Care Account during the period of your leave.*** Your taking the unpaid leave qualifies as a Change Event that would permit you to discontinue your participation in the UHCRA Benefit Program. If you elect to end your coverage under the UHCRA Benefit Program, healthcare expenses Incurred during the period of your leave would not be eligible for reimbursement, even if you resume participation in the UHCRA Benefit Program when you return from your leave. If you have not Incurred Claims that exceed your current contributions, then you may elect to remain out of the UHCRA Benefit Program or you may elect to resume your participation in the UHCRA Benefit Program for the remainder of the calendar year. If you return from the leave during the same

calendar year and you have received reimbursements of Claims in excess of your current contributions, you will resume your participation in the UHCRA Benefit Program for the remainder of the calendar year. When you resume participation in the UHCRA Benefit Program, you may either:

- resume participation at the level in effect before your leave started and increase your pre-tax payroll deductions for the remaining portion of the calendar year to make up the unpaid contributions (which allows you to be reimbursed up to the full amount you had elected for the calendar year); or
- resume participation by keeping your payroll deductions at the same level as was in effect before your leave began (your annual coverage level will be *pro-rated*, and the total amount you will be entitled to be reimbursed from your Health Care Account will be reduced by the amount of the contributions you did not make during the period of your leave).

You may not, however, reduce your benefit elections for the UHCRA Benefit Program below the amount already reimbursed to you from your Health Care Account.

- ***Continue your participation in the UHCRA Benefit Program, but discontinue contributions to your Health Care Account during the period of your leave.*** If you elect to continue your participation in the UHCRA Benefit Program during the period of your leave, upon your return from leave during the same calendar year, your pre-tax payroll deductions will be automatically increased to make up the unpaid contributions you did not make during your leave. Healthcare expenses incurred during your leave are eligible for reimbursement.

Returning From FMLA Leave During a Subsequent Calendar Year

Upon your return to employment with the District during a subsequent calendar year, you will be able to make a new election under the UHCRA Benefit Program for that calendar year. You will not, however, be able to make pre-tax contributions in one Plan Year for coverage that would be effective during a subsequent calendar year.

Before taking a leave of absence, you should discuss your choices with the Benefits Department to determine what choice is best for you.

► LIMITATIONS ON BENEFITS

The UHCRA Benefit Program may not discriminate in favor of Highly Compensated Individuals as to eligibility to participate in and as to benefits provided under the UHCRA Benefit Program. All benefits provided to Highly Compensated Individuals under the UHCRA Benefit Program must be provided to all other UHCRA Benefit Program participants. A “**Highly Compensated Individual**” is one of the five highest paid officers of the District, a shareholder owning more than 10 percent of the District, or one of the highest paid 25 percent of all District employees.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT PROGRAM

The DFSA Benefit Program is designed to help you pay for Eligible Dependent Care Expenses by allowing you to pay these expenses with *pre-tax* dollars. It is intended to qualify as a dependent care assistance plan under Section 129 of the Code and it is part of the cafeteria plan under Section 125 of the Code. Under the Program, you may authorize *pre-tax* contributions, through paycheck deductions, to a Dependent Care Flexible Spending Account (“**Dependent Care Account**”) that the District will establish for you.

Your Dependent Care Account will be credited each payroll period with the paycheck deduction amount you authorized. Your Dependent Care Account is for bookkeeping purposes only and the amounts credited to your Dependent Care Account can only be used to reimburse you for Eligible Dependent Care Expenses or these amounts will be forfeited after the end of the calendar year.

► AMOUNT THAT YOU MAY CONTRIBUTE TO YOUR DEPENDENT CARE ACCOUNT

The maximum amount you may contribute to your Dependent Care Account each calendar year is the *least* of:

- your earned income from employment;
- your Spouse’s earned income from employment; or
- \$5,000 annually (which is the annual maximum income reduction) or \$2,500 annually if you are married, but you and your Spouse file separate federal income tax returns.

The minimum amount you may contribute annually to your Dependent Care Account is \$100.

If your Spouse has not earned any income from employment during the Plan Year, and is a full-time student or disabled and unable to care for himself or herself, your Spouse will be assumed to have earned \$250 a month if you claim reimbursement for the care of one Eligible Dependent, or \$500 a month if you claim reimbursement for the care of two or more Eligible Dependents. A

“full-time student” for this purpose is someone who enrolls during each of at least five months during the taxable year for what is considered a full-time course of study at an ongoing educational organization (as defined in Code Section 170(b)(1)(A)(ii)).

If the amount of your or your Spouse’s earned income changes during the Plan Year, such that the authorized deduction amount exceeds the maximum amount as stated above, then you should immediately notify the Plan Administrator so that the amount of your paycheck deductions can be reduced.

In some circumstances, the Plan Administrator may reduce the amount you may contribute to your Dependent Care Account in order to comply with Code requirements.

► AMOUNT THAT CAN BE REIMBURSED TO YOU

Unlike the UHCRA Benefit Program, you will only be reimbursed for an Eligible Dependent Care Expense to the extent of the current balance in your Dependent Care Account. If the balance in your Account is insufficient to pay an Eligible Dependent Care Expense in full, the unpaid remainder will be carried over and paid when the balance in your account is sufficient.

► ELIGIBLE DEPENDENT CARE EXPENSES

The amounts credited to your Dependent Care Account may only be used to pay for the Eligible Dependent Care Expenses of a Qualifying Individual as defined in Sections 21(b) and 152(a)(1) of the Code.

A “**Qualifying Individual**” is defined as:

- your Child or a descendant of your Child under the age of 13 who:
 - has the same principal place of abode as you for more than one-half of the calendar year; and
 - has not provided over one-half of his or her own support for the calendar year.
- your mentally or physically disabled Spouse or dependents for federal income tax purposes (regardless of age) who:
 - are physically or mentally incapable to care for themselves; and
 - have the same principal place of abode as you for more than one-half of the calendar year.

If you are a parent who is divorced, legally separated, separated under a written separation agreement, or who lived apart from your Spouse at all times during the last six months of the calendar year, your Child will be considered a Qualifying Individual if:

- your Eligible Dependent Child is under the age of 13 or is physically or mentally incapable of caring for himself;
- your Eligible Dependent Child is in the custody of one or both parents for more than one-half of the calendar year; and
- you have custody of your Eligible Dependent Child for more of the calendar year than your Spouse or former Spouse, as the case may be.

“**Eligible Dependent Care Expenses**” are expenses Incurred for household services or care of a Qualifying Individual necessary to enable you to be gainfully employed. Examples of Eligible Dependent Care Expenses include:

- expenses for nursery school, pre-school, or similar programs for your Qualifying Individual below the age of kindergarten;
- expenses for before or after-school care for your Qualifying Individual in kindergarten or a higher grade;
- expenses for a day camp or similar program for your Qualifying Individual;
- indirect expenses that are required to obtain care for your Qualifying Individual such as application fees, agency fees, and deposits (forfeited deposits and payments are not Eligible Dependent Care Expenses if your Qualifying Individual did not receive care); and
- Social Security and unemployment taxes paid by you on behalf of the person who cares for your Qualifying Individual.

If care is provided by a dependent care center (that means, a facility that provides care for more than six individuals who do not reside at the facility, and receives a fee, payment, or grant for providing the services, even if the center is not operated for profit), the center must comply with all applicable state and local laws and regulations for the expense to be eligible for reimbursement.

If care is provided for a disabled Spouse or disabled dependent over age 13, the care must be provided at your home or the dependent or Spouse must regularly spend at least eight hours each day in your home.

► **INELIGIBLE DEPENDENT CARE EXPENSES**

“**Ineligible Dependent Care Expenses**” *do not* qualify for reimbursement under the DFSA Benefit Program and include:

- expenses paid on behalf of an individual who is not a Qualifying Individual;

- expenses paid to a dependent for federal income tax purposes to care for a Qualifying Individual, or expenses paid to your Child who is under the age of 19, to care for a Qualifying Individual;
- expenses for which you have received or will receive federal dependent care tax credits;
- expenses payable under another employer's dependent care reimbursement account program (you are required to supply additional information sufficient for the Claims Administrator to determine the existence of any duplication of Claims payments);
- expenses in excess of the authorized annual elected amount or the maximum amount under the DFSA Benefit Program;
- expenses paid to an ineligible provider (for example, expenses paid to send a dependent to an overnight camp);
- expenses Incurred during a period of time you were not covered by the DFSA Benefit Program;
- expenses Incurred for food, clothing, or education, unless incidental to and inseparable from the care provided (for example, nursery school or pre-school expenses would be eligible even if lunch and some educational services were provided);
- educational expenses for a Child in kindergarten or higher grade level;
- expenses for transportation between your home and the place where the dependent care is provided;
- expenses for which there is no satisfactory proof of payment;
- expenses Incurred by a provider for whom a name, address and Social Security number has not been reported to the Claims Administrator; and
- expenses claimed later than the March 31st following the end of the calendar year.

Any reimbursement paid for an Ineligible Dependent Care Expense under the DFSA Benefit Program will be subject to applicable income and other payroll taxes.

► TAX ADVANTAGES OF PARTICIPATION IN THE DFSA BENEFIT PROGRAM

The DFSA Benefit Program lets you pay up to \$5,000 a year in Eligible Dependent Care Expenses with part of your income that is withheld **before** it is taxed. This lowers your income that is subject to federal income and Social Security taxes as well as state and most municipal taxes, if any.

Example of How the DFSA Benefit Program Saves Money:

You are married and you and your Spouse each earn \$30,000 per year and you are in the 25% tax bracket. You estimate that your yearly Eligible Dependent Care Expenses will be \$3,000. So, you choose to contribute \$3,000 to your Dependent Care Account. Your savings will be:

	Using DFSA Program	Not Using DFSA Program
Your Gross Pay (You and Your Spouse)	\$60,000	\$60,000
Your Pre-Tax Dependent Care Expenses	<u>3,000</u>	<u>N/A</u>
Your Taxable Income	57,000	60,000
Your Income Taxes (25%)	14,250	15,000
Your Post-Tax Dependent Care Expenses	<u>0</u>	<u>3,000</u>
Your Net Take Home Pay	42,750	42,000
Your Savings	\$ 750	N/A

► **FEDERAL DEPENDENT CARE TAX CREDIT**

You are not eligible to receive both federal dependent care tax credits and reimbursement under the DFSA Benefit Program for the same expense. Before enrolling in the DFSA Benefit Program, you should determine whether reimbursement of Eligible Dependent Care Expenses under the DFSA Benefit Program is more advantageous to you than the federal dependent care tax credits that may be available for the same expenses.

The childcare expenses eligible for the federal dependent care tax credit are reduced by the amount that the DFSA Benefit Program reimburses you for childcare expenses. For example, if you have two Qualifying Individuals whose care costs you \$8,000 in dependent care expenses, and you pay \$5,000 on a tax-free basis through the Program, you cannot take a tax credit with respect to the remaining \$3,000, as the maximum childcare expenses eligible for the tax credit are limited to \$6,000. However, you could take the tax credit with respect to \$1,000 of your additional \$3,000 of dependent care expenses as that amount would take you to, but not beyond, the \$6,000 limit.

► **PROVIDER INFORMATION**

When you submit your first DFSA Benefit Program Claim of each year, you must provide the Claims Administrator with information about the dependent care provider including the provider's name, address and Social Security number. If this information changes at any time, you are required to provide the new information with your next DFSA Benefit Program Claim. This information must also be provided to the Internal Revenue Service on your federal income tax return. You may obtain this information from your dependent care provider on IRS Form W-10, "Dependent Care Provider's Identification and Certification."

► EXPENSES ELIGIBLE UNDER MORE THAN ONE DEPENDENT CARE REIMBURSEMENT ACCOUNT

If a dependent care benefit is payable under two or more dependent care reimbursement programs, you may submit a Claim for the expenses to either program, but the DFSA Benefit Program will not pay any expenses paid by another program. At the Claims Administrator's request, you must supply additional information sufficient for the Claims Administrator to determine if Claim payments have been duplicated.

► FORFEITURE OF AMOUNTS REMAINING AT THE END OF THE CALENDAR YEAR

If you do not use the total amount in your Dependent Care Account for reimbursement of Eligible Dependent Care Expenses Incurred during the calendar year, the amount remaining in your account will be forfeited on the April 1st following the end of the calendar year, and will not be returned to you. Forfeited amounts will be used to pay the Plan's administrative expenses.

► TERMINATION OF THE DFSA BENEFIT PROGRAM

In the event the DFSA Benefit Program is terminated, any amounts in your Dependent Care Account will remain available for 90 calendar days after the Program's termination date for reimbursement of Eligible Dependent Care Expenses that were Incurred while the DFSA Benefit Program was in effect (and limited to the current calendar year).

► MAKING CONTRIBUTIONS DURING A FMLA LEAVE OF ABSENCE

If you take a paid or unpaid FMLA leave of absence that lasts for no more than two calendar weeks, you will remain a participant in the DFSA Benefit Program during this time. Any Eligible Dependent Care Expenses Incurred during your FMLA leave are eligible for reimbursement from your Dependent Care Account. If your FMLA leave is unpaid, your pre-tax payroll deductions will be adjusted, when you return from leave during the same calendar year to make up any amounts missed during your FMLA leave.

If your paid or unpaid FMLA leave of absence lasts longer than two calendar weeks, your participation in and Benefit Contributions to the DFSA Benefit Program will end. Any Eligible Dependent Care Expenses Incurred before your FMLA leave are eligible for reimbursement from your Dependent Care Account. Any dependent care expenses Incurred during your FMLA leave are not eligible for reimbursement under the DFSA Benefit Program. When you return from your paid or unpaid FMLA leave, you may elect to participate in the DFSA Program under the Change Event rules.

► LIMITATIONS ON BENEFITS

During the calendar year, the District may not provide more than 25 percent of the benefits under the DFSA Benefit Program to shareholders or owners (or their Spouses or dependents) who own more than five percent of the District.

Under the DFSA Benefit Program, the average benefits provided to non-highly compensated employees of the District must be at least 55 percent of the average benefits provided to highly compensated employees.

► USE OF DEBIT CARD

“*Debit card*” means a banking card enhanced with ATM (automated teller machine) and POS (point-of-sale) features, issued by the Plan Sponsor to a Participant that can be used to pay for qualified medical flexible spending expenses [or qualified dependent care flexible spending expenses]electronically.]

Qualified medical flexible spending expenses may be purchased directly from the merchant or provider of services through the use of a debit card. Similarly, qualified dependent care flexible spending expenses may be purchased directly from the provider of services through the use of a separate debit card. This is a very convenient way to access the benefits of the Plan. Here is how the debit card feature works:

When you enroll in the Plan each year, you must certify that the debit card will only be used for either qualified medical flexible spending expenses, as [defined in Code § 213(d)] or qualified dependent care flexible spending expenses, as defined above. [If you contribute to both a qualified medical flexible spending account and a qualified dependent care flexible spending account, you will receive a separate card for each account.] You must also certify that you will not pay any expense with the debit card that has been reimbursed and that you will not seek reimbursement for the expense under any other plan covering health benefits or dependent care, respectively. The certification will be printed on your debit card, and by using the card, you will reaffirm the certification each time you use the debit card.

When you use the debit card at the point-of-sale, the merchant or provider of service is paid the full amount of either the qualified medical flexible spending expense or the qualified dependent care flexible spending expense (assuming there is sufficient coverage in your account), and your maximum available coverage remaining is reduced by that amount. Your use of the debit card is limited to the maximum dollar amount of coverage available in your qualified medical flexible spending account or your qualified dependent care flexible spending account.

Your debit card is ineffective except at those merchants and providers of service authorized by the Plan, so that the use of the card at other merchants or service providers will be rejected. The Plan limits the debit card’s use to specified Merchant Codes relating to covered health care or dependent care. Thus, the debit card’s use is limited to [physicians, pharmacies, dentists, vision care offices, hospitals and other medical care providers of service or providers of dependent care service].

You must agree to acquire and retain sufficient documentation for any expense paid with the debit card, including invoices and receipts where appropriate. All charges to the debit card are treated as conditional pending confirmation of the eligibility of the charge through your documentation. Within 90 days of using your debit card, you must submit an invoice or receipt from the merchant or provider of service, including the information required under either

Sections “How do I file a claim for qualified medical flexible spending expenses” or “How do I file a claim for qualified dependent care flexible spending expenses” as applicable.

Substantiation of qualified medical flexible spending expenses will be satisfied without additional documentation when:

- The dollar amount of the transaction at a health care provider exactly equals the dollar amount of the copayment under the benefit plan for that service;
- The expense is a recurring expense that exactly matches a previously approved qualified medical flexible spending expense at this provider for the same time period;
- Verification is provided to the Plan through “real-time substantiation” that the expense is a qualified medical flexible spending expense by the provider of service, merchant or independent third party (e.g., Pharmacy Benefit Manager).

Substantiation of qualified dependent care flexible spending expenses will be satisfied without additional documentation when:

- The expense is a recurring expense that exactly matches a previously approved qualified dependent care flexible spending expense at this provider for the same time period; and
- Verification is provided to the Plan through “real-time substantiation” that the expense is a qualified dependent care flexible spending expense by the provider of service, merchant or independent third party.

You should verify that the Plan Administrator considers any expenses substantiated.

If the Plan Administrator finds that any claims have been paid that are not for qualified medical flexible spending expenses or qualified dependent care flexible spending expenses, you are required to refund any amount so identified to the appropriate account. If you fail to promptly refund the overpayment to the Plan, the amount may be withheld from your wages or other compensation to the extent permitted by law. In addition, the Plan reserves the right to suspend your use of the debit card and/or credit the overpayment against other qualified medical flexible spending expenses or qualified dependent care flexible spending expenses, that you may submit until the overpayment refund is satisfied. Amounts overpaid for qualified medical flexible spending expenses will not be credited against qualified dependent care flexible spending expenses and vice versa.

Your debit card will automatically be cancelled if your employment terminates or if your participation in the plan otherwise terminates.

CLAIM FILING AND REVIEW PROCEDURES

In order to receive benefits under a Plan Benefit Program, you will need to file a Claim for benefits. Only those Claims that are for covered benefits under the Plan Benefit Program will be paid. A “**Claim**” is any request for a benefit under a Benefit Program that is made by you or your authorized representative that complies with the Plan’s reasonable procedures for making benefit Claims. If your Claim is denied, you have the right to a review of that denial by the Benefit Program’s Claims Administrator. The Plan’s procedures for filing a Claim are explained below and may differ depending on the kind of Claim that is filed. The Booklet for each Benefit Program may have additional Claims requirements, so you should review those as well.

For purposes of these Claim Filing and Review Procedures, the entity or individual responsible for determining your Claim under a particular Benefit Program is always referred to as the “**Claims Administrator**.” This reference applies to the Plan Administrator or a third party hired by the Plan Administrator for any Self-funded Benefit Programs and it applies to an insurance District for any insured Benefit Programs. Refer to Appendix C for a listing of the Claims Administrators for each Benefit Program.

Time limits apply for filing a Claim, providing more information to complete a Claim, and appealing a denied Claim. The Claims Administrator also must comply with time limits for notifying you of an improper or incomplete Claim, deciding your initial Claim, and reviewing your appeal of a denied Claim. At the end of this section there is a Claims Procedures Time Limits chart that lists all of these time limits.

The terms “you” and “your” in these Claims procedures apply, where appropriate, to your Covered Dependents.

► PROCEDURES FOR ALL BENEFIT PROGRAMS

You, your Covered Dependent or an authorized representative may file a Claim or seek review of any denied Claim.

Authorized Representatives

You may appoint an authorized representative to file your Claim, appeal a denied Claim, and to otherwise represent you for purposes of the Plan’s Claim procedures. The Benefits Department has a form that allows you to appoint an authorized representative. In some cases, your treating physician or other health care provider may become your authorized representative and the Plan will recognize that representation, even though no form has been filed. Otherwise, the Plan will only recognize the person you have authorized on the last dated form you filed with the Plan. Once you have appointed an authorized representative, the Claims Administrator will communicate directly with your representative, and may not also inform you of the status or outcome of your Claim. You will have to seek such information from your representative. If you have not appointed an authorized representative, the Claims Administrator will communicate with you directly.

Notice of Initial Claim Denial

If your Claim under any Benefit Program is denied in whole or in part, the Claims Administrator will provide you with a written or electronic (for example, by e-mail) notice of that denial (“**Notice of Initial Claim Denial**”).

Any adverse benefit determination, including any denial, reduction, or termination in whole or part, of the benefit for which you filed a Claim, or a failure to provide or make payment (in whole or in part) of the benefit for which you filed a Claim, is a Claim denial. This includes any determination based on the eligibility of the person on whose behalf the expense was Incurred or whether the expense itself is eligible for reimbursement. The Notice of Initial Claim Denial will:

- inform you of the specific reasons(s) for the denial of your Claim;
- inform you of the pertinent Plan provisions on which the denial is based;
- provide an explanation of the Plan’s Claim review procedures, including applicable time limits and an explanation of the expedited review procedure for certain types of Claims (for example, Urgent Care Claims);
- contain a description of any additional materials necessary to perfect your Claim, and an explanation of why those materials are necessary;
- include a statement that you have a right to bring a civil action in court if your Claim has been denied after you have asked for and received a review of the initial denial;
- for the health claims and disability claims, reference any rule, guideline, protocol, or similar document or criteria relied on in making the initial determination, and include a statement that a copy of such rule, guideline, or protocol may be obtained upon request at no cost to you; and
- if the Adverse Benefit Determination is based on a matter of medical judgment (for example, under the Medical Benefit Program, it was determined that your treatment was experimental or was not medically necessary), the notice will also contain either an explanation of the scientific or clinical judgment on which the termination was based, or a statement that a copy of that explanation can be obtained upon written request at no cost to you.

Notification of Denial on Review

If you appeal the initial denial of your Claim and, your Claim is also denied in whole or in part on the review, the Claims Administrator will provide you a written or electronic (for example, by e-mail) notice of that denial (“**Notice of Denial on Review**”). The Notice of Denial on Review will:

- inform you of the specific reasons(s) for the denial;
- inform you of the pertinent Plan provision(s) on which the denial is based;
- provide an explanation of any voluntary levels of review that the Plan makes available, if any, including applicable time limits for electing such voluntary review procedures (the Plan’s voluntary review procedures may include arbitration, even binding arbitration, but any arbitration will be offered at no cost to you);
- where an initial adverse determination is based on medical judgment (for example, it was based on an assessment that your treatment was experimental, or was not medically necessary), the notice of any adverse determination on review will contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of that explanation can be obtained upon request at no charge;
- contain a statement that you are entitled to receive, upon request and at no cost to you, reasonable access to and copies of the documents, records, and other information relevant to the decision to deny your Claim (in whole or in part);
- for the health claims and disability claims, reference any rule, guideline, protocol, or similar document or criteria relied on in making the initial determination, and include a statement that a copy of such rule, guideline or protocol may be obtained upon request and at no cost to you; and
- contain a statement that because your Claim was denied on review, you may seek to have your Claim paid by bringing a civil action in court.

Court Review and Failure of the Claimant to Follow These Procedures

All decisions following a review by the Claims Administrator are final and binding. If no review is sought, the decision of the Claims Administrator is final and binding upon the expiration of the time period for seeking review. If your Claim is denied in whole or in part after all stages of these procedures have been completed (except any voluntary levels of review), you have the right to seek to have your Claim paid by filing a civil action in court, but you will not be able to do so unless you have completed all of the levels of review (except any voluntary levels) required under the Plan. If you do not follow and complete these procedures, a review of your Claim in court will be subject to dismissal for your failure to exhaust your Claim and review

rights under this Plan. If you wish to file your Claim in court, you must do so within one year of the date on which you receive Notice of the Denial on Review (or within the time period required by the Claims Administrator for the insured Benefit Programs).

Failure of the Claims Administrator to Follow These Procedures

If the Claims Administrator fails to comply with any of the required deadlines or fails to adequately inform you of your procedural rights, you may treat these procedures as having been completed, and file your Claim in court. You must, however, file your Claim in court within one year (or within the time period required by the Claims Administrator for the insured Benefit Programs) of the date you knew, or should have known, of the Claims Administrator's material failure to comply with these procedures.

► SPECIFIC CLAIMS PROCEDURES FOR MEDICAL, DENTAL AND VISION BENEFIT PROGRAMS AND THE EAP

Filing a Claim

Under the Medical and Dental Benefit Programs, there are different types of Claims. The type of Claim filed determines the time periods for decisions relating to these Claims and where and how you will need to file the Claim. A Claim may be a Pre-Service Claim, an Urgent Care Claim, a Concurrent Care Claim, or a Post-Service Claim. The Dental and Vision Benefit Programs generally only have Post-Service Claims.

If you or your health care provider have not made a proper Pre-Service or Urgent Care Claim under the Plan's Claims procedures, the Claims Administrator will notify you verbally, unless you request written notice, and explain what steps you must take to properly file your Claim ("**Notice of Improper Pre-Service Claim**").

If you have properly filed your Claim, but have not provided sufficient information about the treatment, service, or procedure to be authorized, the Claims Administrator will notify you that more information is needed and will:

- describe the information that is needed;
- request an extension of time in which to decide the Claim; and
- inform you that the information must be received within 45 days from the date you receive the Extension Notice or your Claim will be denied.

If you provide information, but it again turns out to be insufficient, the Claims Administrator will deny your claim.

Pre-Service Claims. A "**Pre-Service Claim**" is a Claim for a benefit under the Plan that is conditioned, in whole or in part, on your obtaining advanced approval for the benefit prior to obtaining the medical or dental care (for example, pre-authorization or pre-certification). A Pre-Service Claim may be one for Urgent Care or for Non-Urgent Care. In most cases, your health

care provider will make your Pre-Service Claims for you. Pre-Service Claims may be made by mail, telephone, or electronic media. All Pre-Service Claims should be made with the Claims Administrator listed in Appendix C.

Approval of your Pre-Service Claim serves only to meet the Plan's pre-authorization or pre-certification requirement so that you will not be penalized. Pre-certification approval is not a guarantee that the Claim will be paid in full, as there may be other reasons to deny your Claim. Once the treatment is provided, the service is rendered, or the procedure is performed, the provider's bill will be processed as a Post-Service Claim.

Urgent Care Claims. Urgent Care Claims are a special variety of Pre-Service Claims. An “**Urgent Care Claim**” is one where applying the standard time frames for non-Urgent Claims:

- could seriously jeopardize your life or health or your ability to regain maximum function; or
- would, in the opinion of a physician with knowledge of your medical condition, cause you severe pain that cannot be adequately managed without the treatment, service, or procedure that is the subject of the Claim.

Absent a determination by your physician, the Claims Administrator will determine whether a Claim is one involving Urgent Care using the judgment of a prudent layperson with average knowledge of health and medicine.

In most cases, your health care provider will make your Urgent Care Claim. All Urgent Care Claims must be made with the Claims Administrator listed in Appendix C. You can submit Urgent Care Claims orally or in writing, and all necessary information may be provided by telephone, facsimile, or any other similarly expeditious method. Other than for requests for additional information, there are no extensions of time for determining Urgent Care Claims.

Post-Service Claims. A “**Post-Service Claim**” is any Claim that is not a Pre-Service Claim. It is a request for the Plan to pay for Medical, Dental and Vision Benefit Program expenses that you have already Incurred. If you receive treatment from a provider who is part of the PPO network or HMO network, present your identification card (or, if no identification card is issued, your other required information) when you receive the treatment, and the provider will send the necessary information directly to the Claims Administrator.

If you have either paid for services out of your own pocket, or the provider has sent a bill directly to you for payment, you should send the Claim form, the bill, and if you have already paid the bill, evidence that you did pay (for example, a cancelled check, or a receipt or a marked “paid” invoice, *etc.*), together with the following information, to the Benefit Program's Claims Administrator listed in Appendix C:

- Contract number printed on your identification card.

- Name and address of the provider.
- Provider’s tax identification number (if known).
- Patient’s name, address, and Social Security number.
- Name, address, and Social Security number of the Plan participant.
- Relationship of the patient to the participant.
- Name and group number of the health plan.
- Date and place of the treatment.
- A description of the treatment (if not already noted on the invoice).
- Any other information, documents, or explanatory materials which you believe support your Claim.

Concurrent Care Claims. If you have been approved for a course of treatment under the Medical Benefit Program, and: (a) it is determined that coverage for your course of treatment is to be reduced or terminated before the treatment is completed (whether that is measured by a pre-set time period or a pre-set number of treatments); or (b) you wish to extend the course of treatment beyond that which was initially authorized, you may file a “**Concurrent Care Claim**” seeking to restore the remainder of the treatment regimen previously approved, or to request an extension of the treatment. You should submit any and all information in support of your Concurrent Care Claim to the Claims Administrator’s address listed in Appendix C.

Decision on Your Initial Claim

The Claims Administrator will make its decision on your initial Claim no later than the time periods indicated in the Claims Procedures Time Limits chart at the end of this section. (You may find additional information on these procedures in the Benefit Program Booklets provided by the Claims Administrator.)

Except for the Urgent Care Claims, the Claims Administrator may ask for an extension of time to decide your Claim (other than for insufficient information), but only if the reason(s) for the requested extension are beyond the control of the Claims Administrator. The notice will contain an explanation as to why the Claims Administrator needs the extension and the date by which your Claim will be decided. The notice of insufficient information and the notice to extend the time to decide your Claim are “**Extension Notices**”.

Claim Review

For Pre-Service, Urgent Care, and Concurrent Care Claims, the Claims Administrator will notify you of the initial Claim decision. For Post-Service Claims, the Claims Administrator

may only notify you if the Claim is denied. In all cases where your Claim has been denied, in whole or in part, you will receive a written Notice of Initial Claim Denial, except for Urgent Care Claims, in which case you may be notified first orally, and then a written or electronic notice will be sent within three days.

If you receive a Notice of Initial Claim Denial and you disagree with that decision, you must file an appeal of that decision by submitting your request for review to the Claims Administrator listed in Appendix C. For Urgent Care Claims, a request for an expedited review may be submitted orally or in writing, and all necessary information may be provided by telephone, facsimile, or any other similarly expeditious method. For Pre-Service, Post-Service, and Concurrent Care Claims, your appeal must be in writing, and transmitted either by mail or any reasonably available electronic media. Your request should include an explanation of why you think your Claim should not have been denied and any additional information, materials, or documentation supporting your Claim.

Depending on the Claims Administrator for these health Benefit Programs, you may have one or two required levels of appeal and voluntary levels of appeal. See Appendix C to find out whether your Claims Administrator has one or two required levels of appeal or any voluntary levels of appeal.

The person(s) reviewing your Claim will grant no deference to either the original Claim denial or the first-level review decision, if applicable, but will assess the information you provide as if they were looking at the Claim for the first time. Also, the person(s) reviewing your Claim will not be the same person(s) who made the initial decision or the prior review (if any), nor will they be subordinate(s) of those individuals. You will also be provided reasonable access to and copies of, all documents, records, and other information relevant to your Claim.

If the initial Claim denial or the first-level review of your Claim, if applicable, is based on medical judgment (for example, it was based on an assessment that your treatment was experimental or was not medically necessary), the Claims Administrator must consult with an expert in the appropriate field when reviewing the Claim. The identity of any expert consulted, whether or not his or her opinion is relied on in determining your Claim, will be retained as information relevant to your Claim.

You will be notified in writing of each decision on review, whether favorable or adverse, within the time frames listed in the Claims Procedures Time Limits chart at the end of this section. Notice of the results of a review of an adverse Urgent Care Claim determination may be provided orally, as long as a written or electronic notice is sent within three days.

If the Benefit Program option has two required levels of appeal and you disagree with the first-level review decision, you must complete a second level of review on your Claim (other than an Urgent Care Claim, for which there is no second level of review available). You must submit your request for second-level review to the Claims Administrator's address listed in Appendix C.

► SPECIFIC CLAIMS PROCEDURES FOR THE DISABILITY CLAIMS OR DETERMINATIONS UNDER THE LTD AND LIFE/AD&D INSURANCE BENEFIT PROGRAMS

Filing a Claim

To file a Claim for LTD Benefit Program benefits, you may obtain a Claim form from the Benefits Department. You will need to complete the Claim form and return it to the Benefits Department within sufficient time for the Benefits Department to complete the Claim form and send it to the Claims Administrator. The Benefits Department will send the completed form and any materials or documentation to the Claims Administrator listed in Appendix C, within the time period specified in the Claims Administrators' Booklets. The Booklets for the LTD Benefit Program have additional Claims procedures that you must follow as well.

For disability determinations under the Life/AD&D Insurance Benefit Program, refer to the Booklet for the Life/AD&D Insurance Benefit Program.

Decision on Your Initial Claim

The Claims Administrator will make its decision on your initial Claim or disability determination within a reasonable time but no later than the time periods indicated in the Claims Procedures Time Limits chart at the end of this section. The Claims Administrator may, however, extend the time periods, as long as the Claims Administrator determines that an extension is necessary due to matters beyond its control, and the Claims Administrator notifies you in a timely manner of why it needs the extension, and the date by which the Claims Administrator expects to decide your Claim. The notice of extension will:

- explain the standards on which entitlement to a benefit is based;
- indicate the unresolved issues that prevent a decision on the Claim;
- describe the additional information that is needed to resolve those issues; and
- tell you that the information must be received within 45 days from the date you receive the notice of extension or your Claim will be denied.

If the Claims Administrator requests additional information and you provide insufficient information again, the Claims Administrator will deny your Claim.

Claim Review

If you receive an Adverse Benefit Determination on your LTD Benefit Program Claim or your disability determination under the Life/AD&D Insurance Benefit Program and you disagree with the decision, you must request that the Claims Administrator review the decision. Written requests for review of a denied Claim must be made to the Claims Administrator at the address found in Appendix C. Your request must be in writing and should include an explanation of why

you think your Claim should not have been denied. Include any documentation you believe supports your Claim.

Upon request and free of charge, you may review and receive copies of the documents, records, and other information relevant to your Claim for benefits. You may also submit written comments, documents, records, and other information relating to your Claim to the Claims Administrator.

The review on your Claim will take into account all comments, documents, records, and other information submitted by you relating to your Claim – even if such information was not submitted or considered in the initial decision of your Claim.

The person(s) reviewing your Claim will grant no deference to the initial Claim denial, or the first level of review, if any, but will assess the information you provide as if they were looking at the Claim for the first time. Also, the person(s) reviewing your Claim will not be the same person(s) who made the initial determination, nor will they be subordinate(s) of those individuals. You will also be provided reasonable access to and copies of, all documents, records and other information relevant to your Claim.

If the initial Claim denial (or the first level of review decision, if any) was based on a medical judgment, the Claims Administrator will consult with an expert in the appropriate field when reviewing the Claim. The identity of any expert consulted, whether or not his or her opinion is relied on in determining your Claim, will be retained as information relevant to your Claim.

The Claims Administrator may have one or two required levels of appeal and voluntary levels of appeal. Refer to Appendix C to find out whether your Claims Administrator has one or two levels of appeal or any voluntary levels of appeal. If the Claims Administrator has two required levels of appeal and you disagree with the first-level review decision, you must complete a second level of review on your Claim. You must submit your request for second-level review to the Claims Administrator's address listed in Appendix C.

The Claims Administrator will notify you in writing of each decision on review, whether favorable or adverse, within a reasonable time period but no later than the time frames listed in the Claims Procedures Time Limits chart at the end of this section.

► SPECIFIC CLAIMS PROCEDURES FOR THE LIFE/AD&D INSURANCE AND PRE-TAX PAYMENT PROGRAMS

Filing a Claim

Life/AD&D Insurance Benefit Programs. To file a Claim for benefits under the Life/AD&D Benefit Programs (other than a disability determination under the Life Insurance Benefit Program), contact the Benefits Department for a Claim form. You will need to complete and return the Claim form to the Benefits Department within sufficient time for the Benefits Department to complete the Claim form and send it to the Claims Administrator. The Benefits Department will send the completed Claim form and any materials or documentation to the Claims Administrator listed in Appendix C, within the time period specified in the Claims Administrators' Booklets. The Booklets for the Life/AD&D Benefit Program have additional Claims procedures that you must follow as well.

Pre-Tax Payment Benefit Program. For the Pre-Tax Payment Benefit Program, you do not need to file a specific Claim for benefits. Once you enroll in the Pre-Tax Payment Benefit Program, the pre-tax benefits automatically follow. If for any reason, however, you believe you have been improperly excluded from participation in the Pre-Tax Payment Benefit Program, you may file a formal Claim in writing to the Claims Administrator listed in Appendix C. Be sure to state:

- why you think you should receive the benefits available under the Pre-Tax Payment Benefit Program;
- why you think you have not been getting the benefit; and
- your name and Social Security number.

Decision on Your Initial Claim

Notice of the decision on your Claim for benefits under the Life/AD&D Insurance and Pre-Tax Payment Benefit Programs will be issued within a reasonable time period, but no later than the time periods specified in the Claims Procedures Time Limits chart. If the Claims Administrator has a special circumstance and needs more time to process your Claim, the Claims Administrator will notify you of the special circumstance and give you the expected date of the final decision. (This is also an Extension Notice.)

Claim Review

If your Claim for benefits under the Life/AD&D Insurance or Pre-Tax Payment Benefit Program is denied, in whole or in part, and you disagree with this decision, you must make a written request to the Program's Claims Administrator for a review of the denial of your Claim. Your written request for review should be submitted to the Claims Administrator's address listed in Appendix C.

Upon request and free of charge, you may review and receive copies of the documents, records, and other information relevant to your Claim for benefits. You may also submit written comments, documents, records, and other information relating to your Claim to the Claims Administrator.

The review on your Claim will take into account all comments, documents, records, and other information submitted by you relating to your Claim – even if such information was not submitted or considered in the initial decision of your Claim. The Claims Administrator will make its decision on your Claim appeal within a reasonable time, but no later than the time periods indicated in the Claims Procedures Time Limits chart at the end of this section.

► SPECIFIC CLAIM PROCEDURES FOR THE DFSA BENEFIT PROGRAM

Filing a Claim

You must file a proper Claim to receive reimbursement for Eligible Dependent Care Expenses under the DFSA Program. You may file a Claim by using a Flex Card or by submitting a Claim on the Claims forms available from the Benefits Department. You can file a Claim with the Claims Administrator listed in Appendix C at any time during, or up to the March 31st following the end of the calendar year. All Claims must meet each of the following important requirements:

- The Claim must be for Eligible Dependent Care Expenses.
- The Claim must be for a paid expense that was Incurred during the calendar year, and during the period which you were a participant in the Program.
- The Claim for a paid expense Incurred during a Plan Year must be submitted **no later than the March 31st following the end of the calendar year**.
- The Claim must be made on a form available from the Benefits Department and must include:
 - the amount, date, and nature of the expense;
 - the name, address, and taxpayer identification number of the person, organization, or entity to which the expense was or is to be paid;
 - the name of the person for whom the expense was Incurred, and the relationship of that person to you;
 - the amount recovered or recoverable from any other source with respect to the expense; and
 - written evidence from an independent third party stating that the expense has been Incurred, the amount of the expense (for example, bills, invoices, receipts, or other writings showing the amount of the expense) and proof that you paid the expense (for example, invoices stamped paid, etc.).

If you discontinue participation in the DFSA Benefit Program during the calendar year, dependent care expenses Incurred after your discontinuation in the Program *will not* be eligible for

reimbursement, regardless of whether funds remain in your Dependent Care Account. If you terminate your employment with the District before the end of the calendar year for which you have established a Dependent Care Account, any amounts remaining in your Account will remain available for reimbursement for Eligible Dependent Care Expenses Incurred while you were a participant in the DFSA Benefit Program until the March 31st following the end of the calendar year.

The Claims Administrator will review all DFSA Benefit Program Claims that are submitted and reserves the right to deny ineligible or improperly documented expenses and require additional verification of expenses. Deliberate submission of ineligible claims may result in your removal from the DFSA Benefit Program.

Decision on Your Initial Claim

Notice of the decision on your Claim will be issued within a reasonable time period, but no later than the time period specified in the Claims Procedures Time Limits chart at the end of this section. If the Claims Administrator has a special circumstance and needs more time to process your Claim, the Claims Administrator will notify you of the special circumstance and give you the expected date of the final decision.

Claim Review

If your Claim for benefits under the DFSA Benefit Program is denied, in whole or in part, and you disagree with this decision, you must make a written request to the Benefit Program's Claims Administrator for a review of the denial of your Claim. Your written request for review should be submitted to the Claims Administrator listed in Appendix C.

Upon request and free of charge, you may review and receive copies of the documents, records, and other information relevant to your Claim for benefits. You may also submit written comments, documents, records, and other information relating to your Claim to the Claims Administrator.

The review on your Claim will take into account all comments, documents, records, and other information submitted by you relating to your Claim – even if such information was not submitted or considered in the initial decision of your Claim. The Claims Administrator will make its decision on your Claim appeal within a reasonable time, but no later than the time periods indicated in the Claims Procedures Time Limits chart at the end of this section.

► SPECIFIC CLAIM PROCEDURES FOR THE UHCRA BENEFIT PROGRAM

Filing a Claim

You must file a proper Claim to receive reimbursement for Eligible Health Care Expenses under the UHCRA Benefit Program. You may file a Claim by using a Flex Card or by submitting a Claim on the Claim forms available from the Benefits Department. You can file a Claim with the Claims Administrator listed in Appendix C at any time during, or up to the March

31st following the end of the calendar year. All Claims must meet each of the following important requirements:

- The Claim must be for an expense Incurred by you or that of your Eligible Dependent.
- The Claim must be for Eligible Health Care Expenses.
- The Claim must be for an expense that was Incurred during the calendar year and during the period which you were a participant in the UHCRA Benefit Program.
- The Claim for an expense Incurred during a Plan Year must be submitted **no later than the November 30th following the end of the plan year.**
- If you submit a paper Claim, the Claim must be made on a form available from the Benefits Department and must include:
 - the amount, date and nature of the expense;
 - the name and address of the person, organization or entity to which the expense was paid;
 - the name of the person for whom the expense was Incurred, and the relationship of that person to you;
 - the amount recovered or recoverable from any other source with respect to the expense; and
 - written evidence from an independent third party stating that the expense has been Incurred, the amount of the expense (for example, bills, invoices, receipts, or other writings showing the amount of the expense).

If you discontinue participation in the UHCRA Benefit Program during the calendar year, and you subsequently incur additional expenses, then these new Claim(s) will **not** be eligible for reimbursement, regardless of whether or not funds remain in your account, unless you elect COBRA Continuation Coverage. (*See* the section titled, “COBRA Continuation Coverage”). If you terminate your employment with the District before the end of the calendar year for which you have established a Health Care Account, any amounts remaining in your Account(s) will remain available for reimbursement for Claims Incurred while you were a participant until the March 31st following the end of the calendar year.

The Claims Administrator will review all Claims submitted and reserves the right to deny ineligible or improperly documented expenses and require additional verification of expenses. Deliberate submission of ineligible claims may result in your removal from the UHCRA Benefit Program.

Decision on Your Initial Claim

Notice of the decision on your Claim will be issued within a reasonable time period, but no later than the time period specified in the Claims Procedures Time Limits chart at the end of this section.

Claim Review

If your initial Claim for benefits is denied and you disagree with this decision, you must make a written request to the Benefit Program's Claims Administrator for a review of that decision.

Your request for review should be in writing, and transmitted either by mail or any reasonably available electronic media to the Claims Administrator listed in Appendix C. Your request should include an explanation of why you think your Claim should not have been denied. You should include any additional information, materials or documentation which you believe supports your Claim.

Upon request and free of charge, you may review and receive copies of the documents, records, and other information relevant to your Claim for benefits. You may also submit written comments, documents, records, and other information relating to your Claim to the Claims Administrator.

The person(s) reviewing your Claim will grant no deference to the original Claim denial, and will assess the information you provide as if they were looking at your claim for the first time. Also, the person(s) reviewing your Claim will not be the same person(s) who made the determination on your initial Claim, nor will they be subordinates to those individuals.

If the initial Claim denial was based on a medical judgment, the Claims Administrator will consult with an expert in the appropriate field when reviewing the Claim. The identity of any expert consulted, whether or not his or her opinion is relied on in determining your Claim, will be retained as information relevant to your Claim.

The UHCRA Benefit Program has only one level of review. The Claims Administrator will make its decision on your Claim appeal within a reasonable time, but no later than the time periods indicated in the Claims Procedures Time Limits chart at the end of this section. There are no extensions permitted for making review decisions.

CLAIMS PROCEDURES TIME LIMITS

	HEALTH CLAIMS UNDER THE MEDICAL, DENTAL, VISION AND UHCRA BENEFIT PROGRAMS AND THE EAP				DISABILITY CLAIMS DETERMINATIONS UNDER THE LTD AND LIFE/AD&D BENEFIT PROGRAMS	BENEFIT CLAIMS UNDER ALL OTHER BENEFIT PROGRAMS
	Urgent Care Claims	Pre-Service Claims	Post-Service Claims and UHCRA Claims	Concurrent Care Claims		
Claims Administrator's Notice Of Improper Pre-Service Claim	*24 hours after receiving improper Urgent Care Claim.	5 days after receiving improper Claim.	N/A	*24 hours after receiving improper Urgent Care Claim.	N/A	N/A
Claims Administrator's Notice of Incomplete Claim	24 hours after receiving incomplete Claim.	N/A	N/A	N/A	N/A	N/A
Claims Administrator's Notice of Initial Claim Denial	*48 hours after receiving completed Claim or after the 48-hour participant deadline, whichever is earlier. 72 hours after receiving the initial Claim, if it was proper and complete.	**15 days after receiving the initial Claim. 30 days after receiving the Claim if Claims Administrator needs more information or needs more time for reasons beyond its control and if Claims Administrator provides an Extension Notice during initial 15-day period.	30 days after receiving the initial Claim. 45 days after receiving the Claim if Claims Administrator needs more information or needs more time for reasons beyond its control and if Claims Administrator provides an Extension Notice during initial 30-day period.	*24 hours after receiving the Claim involving Urgent Care if the participant made the Claim at least 24 hours before the prescribed period or treatment expired. All other Concurrent Care Claims will be decided quickly so that participant will have sufficient time to appeal that decision before the scheduled course of treatment ends.	45 days after receiving the initial Claim. 75 days after receiving the Claim if Claims Administrator needs more information or needs more time for reasons beyond its control and if Claims Administrator provides notice during initial 45 day period. 105 days after receiving the Claim, if the Claims Administrator needs more information and if Claims Administrator provides notice during the initial 30-day extension period.	90 days after receiving the initial Claim. 180 days after receiving the Claim if the Claims Administrator needs extension for special circumstances and if Claims Administrator provides an Extension Notice during initial 90-day period.
Participant Deadline to Complete Non-Urgent Claim	N/A	45 days after receiving Extension Notice.	45 days after receiving Extension Notice.	N/A	45 days after receiving notice of extension.	N/A
Participant Deadline to Appeal Decision	180 days after receiving Claim denial.	180 days after receiving Claim denial.	180 days after receiving Claim denial.	In time to continue course of treatment uninterrupted.	180 days after receiving Claim denial.	60 days after receiving the Claim denial.
Claims	* 72 hours	** 30 days after	60 days after	72 hours, 30	45 days after receiving the	60 days after

* The Claims Administrator will give this Notice as soon as possible, but not later than the stated time period.

** The Claims Administrator must give this Notice within a reasonable period of time appropriate to the medical circumstances, but not later than the stated time period.

CLAIMS PROCEDURES TIME LIMITS

	HEALTH CLAIMS UNDER THE MEDICAL, DENTAL, VISION AND UHCRA BENEFIT PROGRAMS AND THE EAP				DISABILITY CLAIMS DETERMINATIONS UNDER THE LTD AND LIFE/AD&D BENEFIT PROGRAMS	BENEFIT CLAIMS UNDER ALL OTHER BENEFIT PROGRAMS
	Urgent Care Claims	Pre-Service Claims	Post-Service Claims and UHCRA Claims	Concurrent Care Claims		
Administrator's Notice of Appeal Decision	<p>after receiving appeal.</p> <p>No extensions for decisions on review.</p>	<p>receiving the appeal.</p> <p>15 days after receiving an appeal if Claims Administrator requires two levels of appeal.</p> <p>No extensions for decisions on review.</p>	<p>receiving the appeal.</p> <p>30 days after receiving an appeal if Claims Administrator requires two levels of appeal.</p> <p>No extensions for decisions on review.</p>	<p>days or 60 days after receiving an appeal (depending on the nature of the Claim), if Claims Administrator has one level of appeal.</p> <p>72 hours, 15 days or 30 days after receiving an appeal (depending on the nature of the Claim), if Claims Administrator has two levels of appeal.</p> <p>No extensions for decisions on review.</p>	<p>appeal (shorter time period if Claims Administrator allows two levels of appeal).</p> <p>90 days after receiving the appeal if Claims Administrator determines that special circumstances require an extension and provides written notice during the initial 45-day period.</p>	<p>receiving the appeal.</p> <p>120 days after receiving the appeal if Claims Administrator determines that special circumstances require an extension and provides written notice during the initial 60-day period.</p>
Participant Deadline to Appeal First-Level Review Decision	N/A	<p>60 days after receiving denial of the first-level appeal, or</p> <p>180 days after receiving Claim denial, whichever is later.</p>	<p>60 days after receiving denial of the first-level appeal, or</p> <p>180 days after receiving Claim denial, whichever is later.</p>	In time to continue course of treatment without interruption.	60 days after receiving denial of the first-level appeal.	N/A

* The Claims Administrator will give this Notice as soon as possible, but not later than the stated time period.

** The Claims Administrator must give this Notice within a reasonable period of time appropriate to the medical circumstances, but not later than the stated time period.

PLAN ADMINISTRATION

► PLAN ADMINISTRATION

The District is the Plan Administrator and has sole responsibility for the administration of the Plan. The Plan Administrator has full discretionary authority to: interpret the Plan; determine eligibility for and the amount of benefits; determine the status and rights of participants, beneficiaries and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms (including the Enrollment Form); employ or appoint persons to help or advise in any administrative functions; to appoint trustees; and generally do anything needed to operate, manage and administer the Plan. The Plan Administrator has the necessary discretionary authority and control over the Plan to require deferential judicial review.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. For the insured benefits, the Plan Administrator has delegated its fiduciary duties with respect to Claims processing and benefit determinations to the insurance companies. For the Self-funded Benefit Programs, the Plan Administrator has delegated its fiduciary duties with respect to initial and in some cases, final Claims determinations to the Claims Administrator listed in Appendix C. These delegates have the full extent of the Plan Administrator's authority and duties with respect to those responsibilities delegated to them.

Each fiduciary is solely responsible for its own improper acts or omissions. No fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary.

► INDEMNIFICATION

The District will indemnify each employee to whom it has delegated responsibilities for the operation and administration of the Plan against any and all claims, loss, damages, expense and liability arising from any action or failure to act, except when it is judicially determined to be due to the gross negligence or willful misconduct of the employee. The District may choose, at its own expense, to purchase and keep in effect sufficient liability insurance to cover any claim, loss, damage, expense or liability arising from any employee's action or failure to act.

► DISCRETION/NONDISCRIMINATION

Wherever it is provided in the Plan that the District may perform or not perform any act, or permit or consent to any action, non-action or procedure, or wherever they are given discretionary power or authority, they have exclusive discretion; provided, however, that they may not exercise their discretion so as to knowingly to discriminate either for or against any employee, participant or Covered Dependent or any group of such persons.

▶ TYPE OF PLAN ADMINISTRATION

Some of the benefits provided under the Plan are insured by various insurance companies and some are Self-funded and administered by the Claims Administrator listed in Appendix A. For some of the Self-funded Benefit Programs, the District has designated third parties to provide administration services for these Benefit Programs under an administrative services contract. These third parties merely process Claims and make initial and in some cases, final Claims determinations. They do not insure that any of your benefits will be paid. Appendix A lists what Benefit Programs are Self-funded and what Benefit Programs are insured.

OTHER IMPORTANT INFORMATION ABOUT THIS PLAN

▶ PLAN NAME

Plymouth-Canton Community Schools Employee Benefit Plan

▶ PLAN NUMBER

501

▶ PLAN SPONSOR, PLAN ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS

Plymouth-Canton Community Schools
454 South Harvey Street
Plymouth, MI 48170
734.416.4834

▶ EMPLOYER IDENTIFICATION NUMBER

38-6004186

▶ PLAN YEAR

September 1st through August 31st

▶ TYPE OF PLAN

The Plan is a welfare benefits plan offering the following benefits: medical, dental, vision, prescription drug, life, accidental death and dismemberment, and long term disability benefits; and a cafeteria plan offering pre-tax contributions for medical, dental and vision coverage, after-tax contributions for supplemental life insurance and optional long term disability benefits, a health care flexible spending account and a dependent care flexible spending account. Not all benefits are available to each group of employees eligible to participate in the Plan. *See* Appendix A.

► PLAN FUNDING

The District pays part of the cost for some Benefit Programs and you are responsible (through your Benefit Contributions) for paying your share of the cost of these Benefit Programs for yourself and your family. The District pays the entire cost for some Benefit Programs, while you pay the full cost of coverage for other Benefit Programs. Appendix B lists the Benefit Programs that have Benefit Contributions and the Benefit Programs that are entirely paid for by the District.

You are also responsible for Coinsurance, Copayments and Deductibles that may be required under the terms of the Benefit Programs. The “**Coinsurance**” is your cost sharing amount of expenses after you have met the Deductible. The “**Copayment**” is the flat dollar amount of health care expenses you incur that you are responsible for paying. The “**Deductible**” is the amount you must pay each year for healthcare expenses before any benefits are payable under the Plan. *See* the Booklets prepared by the Claims Administrators for more information relating to the Coinsurance, Copayments and the Deductibles.

The benefits provided under the Plan will be paid from the general assets of the District, employee contributions, and insurance contracts. Nothing in this Plan will be construed to require the District to maintain any fund for its own contributions or segregate any amount which it is obligated to contribute for the benefit of any participant, and no participant or other person will have any Claim against, right to, or security or other interest in, any fund, account or asset of the District from which any payment under the Plan may be made.

► AMENDMENT OR TERMINATION OF THE PLAN

Plymouth-Canton Community Schools, acting through its Board of Directors or the Board’s authorized designees, may amend, modify, or terminate this Plan at any time in any manner or with respect to any individual, including but not limited to employees, Eligible Dependents, retirees and disabled individuals, in its sole discretion. Any amendment adopted will be in writing and executed by the individual so authorized by the District. Any amendment may be made effective retroactively. Coverage upon Plan termination will be governed by the terms of each Benefit Program.

► NONDISCRIMINATION RULES

For each calendar year, the nontaxable Plan benefits provided to “key employees” (as defined in Section 416(i) of the Code) cannot exceed 25 percent of the aggregate nontaxable benefits provided to all Plan participants. In addition, the Plan cannot discriminate in favor of certain “highly compensated individuals” and/or certain “highly compensated participants” (as defined in Sections 79, 105(h)(5), 125(e)(1), 125(e)(2), 129(d)(2) and 129(d)(8) of the Code) as to the eligibility to participate or as to contributions or benefits.

If, at any time, the District determines that the Plan may not satisfy any of these nondiscrimination rules, the District may take whatever action it deems appropriate to assure compliance with the rule. Any action will be taken uniformly with respect to similarly situated Plan participants. The action may include, without limitation, the modification of your Enrollment Form,

with or without your consent. Should it be necessary to take such action with respect to your Plan benefits, you will be notified of the action to be taken.

► COMPLIANCE WITH TAX LAW

This Plan will comply with all applicable law, including Sections 79, 105, 125, and 129 of the Code and it will be considered amended to the extent necessary to comply with applicable law. Neither the Plan, the Plan Sponsor, the Plan Administrator, nor any Plan fiduciary represents or guarantees that this Plan in fact meets the requirements of any applicable law. Notwithstanding any other provision of this Plan, individuals who are not treated as employees for purposes of the tax treatment of any contribution to any Benefit Program are not eligible to participate in the Plan. The Plan cannot be operated so as to defer the receipt of compensation in a manner that violates Section 125 of the Code.

Section 79 of the Code requires that the District calculate each year imputed taxable income for employees that receive group term life insurance in an amount that exceeds \$50,000 in coverage. The amount of imputed income is calculated by the District and included in your gross income and reported on your Form W-2, Wage and Tax Statement. The imputed income under Section 79 of the Code is not subject to Federal income tax withholding, but is subject to FICA (Social Security and Medicare) taxation.

► HIPAA NONDISCRIMINATION RULES

For purposes of the Medical and Dental Benefit Programs, the Plan may not establish rules for eligibility based on your health status, medical condition, claims experience, receipt of health care (except for permitted pre-existing condition limitations), medical history, genetic information, or evidence of insurability (“**Health Status-Related Factors**”). The Plan may not charge you a higher Benefit Contribution, as compared to the Benefit Contributions charged to similarly situated participants enrolled in the Medical and Dental Benefit Programs, based upon a Health Status-Related Factor.

► GINA NONDISCRIMINATION RULES

Effective as of December 1, 2009, the Plan will comply with the Genetic Information Nondiscrimination Act of 2008 (“**GINA**”). GINA applies to the Plan’s Medical and Dental Benefit Programs. Under GINA, the plan may not discriminate based on Genetic Information by:

- adjusting premium or contribution amounts for participants based on participants’ Genetic Information;
- requiring or requesting that you or your family member take a genetic test;
- requiring, requesting or purchasing Genetic Information for underwriting purposes; or
- requiring, requesting or purchasing Genetic Information with respect to you before you enroll in the Plan.

“**Genetic Information**” means information relating to genetic testing (for example, DNA analysis) of you or members of your extended family and your family history of a disease or disorder.

► **PARTICIPATING EMPLOYERS**

United States affiliates and subsidiaries of Plymouth-Canton Community Schools may adopt the Plan, subject to Plymouth-Canton Community School’s consent. Any affiliate or subsidiary of Plymouth-Canton Community Schools that participates in the Plan cannot amend or terminate the Plan itself, but it may, acting through its Board of Directors or delegate, and subject to the consent of Plymouth-Canton Community Schools, terminate its participation in the Plan or any of the Plan’s Benefit Programs. The affiliates and subsidiaries of Plymouth-Canton Community Schools that have adopted the Plan are listed in Appendix E.

► **QUALIFIED MEDICAL CHILD SUPPORT ORDERS**

The Plan Administrator shall honor an order that is a “**Qualified Medical Child Support Order**” including a National Medical Support Notice, within the meaning of ERISA Section 609(a)(2)(A) (“**QMCSO**”). The Plan Administrator has established written procedures for determining whether a medical child support order is a QMCSO and for administering the provision of benefits under the Plan pursuant to a valid QMCSO. These procedures are available from the Plan Administrator upon written request at no charge. The Plan Administrator has full discretionary authority to determine whether a medical child support order is “qualified” within the meaning of ERISA Section 609(a)(2)(A), and reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency that issued the order, up to and including the right to seek a hearing before the court or agency.

► **MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS**

The Plan will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a state plan for medical assistance as provided under Title XIX of the Social Security Act (“**State Medicaid Plan**”) either in enrolling that individual as a participant or beneficiary or in determining or making any payment of benefits to that individual. The Plan will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid Plan pursuant to Section 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and this Plan has a legal liability to make payments for the same items or services, payment under the Plan will be made in accordance with any state law which provides that the State has acquired the rights with respect to such individual to payment for such items and services under this Plan.

► MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

Medicare provides voluntary prescription drug coverage to eligible individuals, commonly referred to as Medicare Part D. If you are eligible for Medicare Part D, you may need to enroll in Medicare Part D to avoid extra late enrollment penalties. Late enrollment penalties may apply to you if your health coverage does not provide prescription drug coverage that is “creditable”, which means on average for all participants, it is expected to pay out as much as the standard Medicare prescription drug coverage benefit.

The District will issue you a notice stating whether the prescription drug coverage under the Medical Benefit Program option you have selected provides creditable prescription drug coverage or non-creditable prescription drug coverage. This notice will be provided with the Plan’s open enrollment materials each year, and within 30 days after a change that affects whether the prescription drug coverage is creditable or upon request. If the notice is not included in the Plan’s open enrollment materials, the District will provide the notice before the Medicare part D Annual Coordinated Election Period (beginning November 15th through December 31st) each year and before your Initial Enrollment Period for Medicare Part D.

If the Medical Benefit Program provides creditable prescription drug coverage, you will need to retain that notice and provide it to the Centers for Medicare and Medicaid when you enroll in Medicare Part D to avoid paying higher premiums for the Medicare Part D coverage. If the Medical Benefit Program provides non-creditable prescription drug coverage, you will need to enroll in Medicare Part D when you are first eligible in order to avoid a late enrollment penalty. If you are not sure that your prescription drug coverage is creditable, you may want to enroll in Medicare Part D when you first become eligible to avoid any late enrollment penalties.

The District will also issue a notice to the Centers for Medicare and Medicaid Services (“CMS”) stating whether the prescription drug coverage under the Health Benefit Program provides creditable prescription drug coverage or non-creditable prescription drug coverage. This notice will be provided on an annual basis and upon any change that affects whether the drug coverage is creditable by completing the online CMS Creditable Coverage Disclosure form at <http://www.cms.hhs.gov/creditablecoverage>. The annual notice will be provided no later than 60 days after the beginning date of the Plan Year. Notice of changes in creditability (for example, termination of the drug plan) will be given within 30 days after the change in creditable coverage status.

► CERTIFICATES OF CREDITABLE COVERAGE

A Certificate of Creditable Coverage documenting the nature and duration of Medical Benefit Program coverage under this Plan will be sent by first class mail to the last known address of any participant and Covered Dependent Spouse (and any Covered Dependent Child, if living separately):

- when the individual ceases to be covered under the Plan, and
- if the individual elects COBRA Continuation Coverage, when COBRA Continuation Coverage ceases.

In addition, an individual may request a Certificate of Creditable Coverage from the Plan Administrator anytime within a period of 24 months after the end of coverage (including COBRA Coverage).

“Creditable Coverage” is the period of time that you or your dependents have been covered by any of the following medical programs: this Plan; another Group Health Plan; group or individual health insurance coverage issued by a state-regulated insurer; Medicare Part A or Part B; Medicaid; the active military health program, TRICARE; a medical care program of the Indian Health Service or of a tribal organization; a State health benefits risk pool; a qualified high risk pool under the Public Health Services Act; Federal Employees Health Benefits Program; State Children’s Health Insurance Program; state sponsored health coverage arrangements for high risk individuals; a public health plan (as defined in the regulations under HIPAA); or the Peace Corps Health Program; provided, however, that if an individual is not covered by any of these programs for a period of 63 consecutive days or more, then the coverage prior to that 63-day period will not count as Creditable Coverage.

A **“Group Health Plan”** is an employee welfare benefit plan to the extent the plan provides medical care (including items or services paid for as medical care) to employees (and former employees) or their dependents directly or through insurance, reimbursement or otherwise.

You can use this Certificate of Creditable Coverage to show another Group Health Plan (like your Spouse’s) that you had health coverage under this Plan. Periods of Creditable Coverage will reduce, day for day, a period during which a Group Health Plan may exclude you from health coverage due to a Pre-existing Condition. A **“Pre-existing Condition”** is a medical condition for which you received treatment (including any diagnosis from a physician or incurring an expense for that condition) during the six months before your enrollment date for that Group Health Plan.

The Medical Benefit Program under this Plan, however, does **not** impose a Pre-existing Condition exclusion.

► MATERNITY BENEFITS

Pursuant to federal law, the Plan, or any insurance issuer providing coverage for maternity benefits under the Plan, will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law does not prohibit the mother’s or newborn’s treating physician, after consultation with the mother, from discharging the mother or her newborn Child earlier than 48 hours (or 96 hours, as the case may be). The Plan will not require a medical provider to obtain authorization from the Plan (or the insurance issuer) for prescribing a length of stay not in excess of the above periods. Nothing in this provision, however, requires that a woman covered under this Plan give birth in a hospital or stay in the hospital a fixed period of time following the birth of her Child.

► POST-MASTECTOMY BENEFITS

If you receive benefits in connection with a mastectomy under any Benefit Program, you are also covered for the following benefits, which you may elect in consultation with your attending physician:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthesis and treatment of physical complications from all stages of mastectomy, including lymphedemas.

These coverages are subject to applicable contributions and deductibles as are consistent with those established for other medical benefits available to you under your Benefit Programs.

► LIMITATION ON RIGHTS

The Plan does not constitute a contract between you and the District, nor is it to be consideration or inducement for your employment. Nothing contained in the Plan gives you the right to be retained in the service of the District or to interfere with the right of the District to discharge you at any time, with or without cause, regardless of the effect that the discharge will have upon you as a participant in the Plan.

► OVERPAYMENTS

An “**Overpayment**” occurs if the Plan pays an amount not payable under the Plan, if the Plan pays an expense or benefit more than once, or if an expense or benefit is paid by both the Plan and a third party. An expense or benefit is considered paid if it is paid to you or to someone else (for example, to a health care provider) on your behalf.

If an Overpayment is made by the Plan, the Plan has the right to recover the Overpayment. If that Overpayment is made to a health care provider, the Plan may request a refund of the Overpayment from either you or the provider. If the refund is not received from either you or the provider, the Overpayment will be deducted from future Plan benefits available to you or your Covered Dependents or from your wages, but the amounts withheld may not reduce your pay below the applicable state minimum wage law to the extent permitted by law.

► ENTIRE REPRESENTATION

This document along with any Booklet, separate insurance contract, policy or certificate that applies to the Plan’s Benefit Programs; are the entire description of the benefits provided under the Plan. They supersede any previous or contemporary document, representation, negotiation, or agreement (whether written or oral), including, but not limited to, severance agreements and employment agreements.

► ACCEPTANCE; COOPERATION

If you accept benefits under this Plan, you are considered to have accepted its terms, and you agree to perform any act and to execute any documents which may be necessary or desirable to carry out the terms of this Plan.

► GOVERNING LAW

The Plan is to be construed and enforced in accordance with the laws of the State of Michigan, to the extent not preempted by federal law.

► CONSTRUCTION

Words used in the masculine apply to the feminine where applicable. Wherever the context of the Plan dictates, the plural should be read as the singular, and the singular as the plural. Where any time period is given in days, the reference is to calendar days, unless otherwise specified.

► NON-ASSIGNABILITY OF RIGHTS

No interest under the Plan is subject to assignment or alienation, whether voluntary or involuntary. Any attempt to assign or alienate any interest under the Plan will be void.

► ERRORS

An error cannot give a benefit to you if you are not actually entitled to the benefit.

► SEVERABILITY

The enforceability of any provision of the Plan will not affect the enforceability of the remaining provisions of the Plan.

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EXECUTION

IN WITNESS WHEREOF, Plymouth-Canton Community Schools causes this amendment and restatement of the Plan, captioned "Plymouth-Canton Community Schools Employee Benefit Plan," to be executed by its duly authorized officer this 8th day of February, 2011, to be effective as of September 1, 2010.

PLYMOUTH-CANTON COMMUNITY SCHOOLS

By:

A handwritten signature in cursive script, appearing to read "Ray Bihun", with a long horizontal flourish extending to the right.

Ray Bihun

Title: Executive Director of Human Resources

APPENDIX A

EMPLOYEE CLASSIFICATION	BENEFITS AVAILABLE
Superintendent	Medical, Voluntary Life, Self-funded Dental, Voluntary Long Term Disability, Self-funded Vision, Administrative Supplemental Fringe, EAP and Flexible Spending Accounts.
Assistant Superintendents and Executive Directors	Medical, Voluntary Life, Self-funded Dental, Voluntary Long Term Disability, Self-funded Vision, Administrative Supplemental Fringe, EAP and Flexible Spending Accounts.
Affiliated Administrators	Medical, Life/AD&D, Self-funded Dental, Long Term Disability, Self-funded Vision, Administrative Supplemental Fringe, EAP and Flexible Spending Accounts.
Non-Affiliated Administrators	Medical, Voluntary Life, Self-funded Dental, Voluntary Long Term Disability, Self-funded Vision, Administrative Supplemental Fringe, EAP and Flexible Spending Accounts.
Bus Monitors (less than 4 hours per day)	Term Life and EAP.
Bus Monitors	Medical, Life/AD&D, Self-funded Dental, Long Term Disability, Self-funded Vision, EAP and Flexible Spending Accounts.
Cafeteria (working under 25 hours)	Term Life and EAP.
Cafeteria (working 25 hours or more weekly)	Medical or Opt out, Life, Self-funded Dental, Long Term Disability, Self-funded Vision, EAP and Flexible Spending Accounts.
Clerical	Medical, Life, Self-funded Dental, Long Term Disability, Self-funded Vision, EAP and Flexible Spending Accounts.
Custodial/Maintenance	Medical, Life, Self-funded Dental, Long Term Disability, Self-funded Vision, EAP and Flexible Spending Accounts.
Dispatcher	Medical, Life, Self-funded Dental, Long Term Disability, Self-funded Vision, EAP and Flexible Spending Accounts.

Extended Day (Employees working 20 hours or more per week)	Medical (single coverage only), EAP and Flexible Spending Accounts.
Early Childhood	Medical (single coverage only), EAP and Flexible Spending Accounts.
Licensed Technicians	Medical, Life, Self-funded Dental, Long Term Disability, Self-funded Vision, EAP and Flexible Spending Accounts.
Plant Engineers	Medical, Life, Self-funded Dental, Long Term Disability, Self-funded Vision, EAP and Flexible Spending Accounts.
Paraprofessionals (20 hours or less)	Life and EAP.
Paraprofessionals	Medical, Life, Self-funded Dental, Long Term Disability, Self-funded Vision, EAP and Flexible Spending Accounts.
Security Guards	Medical, Life, Self-funded Dental, Long Term Disability, Self-funded Vision, EAP and Flexible Spending Accounts.
Teachers	Medical, Life, Dental, Long Term Disability, Self-funded Vision, EAP and Flexible Spending Accounts.
Transportation	Medical, Life, Self-funded Dental, Long Term Disability, Self-funded Vision, EAP and Flexible Spending Accounts.
Vocational Technicians (4 hours or more daily, FT) (Less than 4 hours daily, PT)	Life and EAP.

APPENDIX B

BENEFIT PROGRAM FUNDING, ADMINISTRATION, BENEFIT CONTRIBUTIONS AND EMPLOYEE GROUP PARTICIPATION

BENEFIT PROGRAM	FUNDING TYPE	CLAIMS ADMINISTRATOR	WHO PAYS FOR COVERAGE*
MEDICAL	Self-funded	Blue Cross Blue Shield of Michigan P. O. Box 2888 Detroit, MI 48231 800. 637-2227 800.810.2583 (Network Providers) <i>www.bcbsm.com</i>	Depending on your classification, you and the District share in the cost of this coverage.
DENTAL	Insured	Delta Dental of Michigan 4100 Okemos Road Okemos, MI 48864 (800) 524-0149 <i>www.deltadentalmi.com</i>	The District pays for the cost of this coverage.
DENTAL	Self-funded	Meritain Health P.O. Box 30111 Lansing, MI 48909 (800) 748-0003, ext. 5 <i>www.mymeritain.com</i>	The District pays for the cost of this coverage.
VISION	Self-funded	Meritain Health P.O. Box 30111 Lansing, MI 48909 (800) 748-0003, ext. 5 <i>www.mymeritain.com</i>	The District pays for the cost of this coverage.
LTD	Insured	CIGNA Group Insurance 1601 Chestnut Street Philadelphia, PA 19192 (800) 732-1603 <i>www.cigna.com</i>	The District pays for the cost of this coverage.
VOLUNTARY LTD	Insured	MetLife 200 Park Avenue New York, NY 10166 (800) 683-5433 <i>www.mymetlife.com</i>	The Non-Affiliated Administrators pay for the cost of this coverage through post-tax contributions.
LIFE/AD&D INSURANCE	Insured	CIGNA Group Insurance 1601 Chestnut Street Philadelphia, PA 19192 (800) 732-1603 <i>www.cigna.com</i>	The District pays for the cost of this coverage.

*You are always responsible for any Benefit Program Coinsurance, Copayments or Deductibles.

APPENDIX B

BENEFIT PROGRAM FUNDING, ADMINISTRATION, BENEFIT CONTRIBUTIONS AND EMPLOYEE GROUP PARTICIPATION

BENEFIT PROGRAM	FUNDING TYPE	CLAIMS ADMINISTRATOR	WHO PAYS FOR COVERAGE*
VOLUNTARY LIFE	Insured	MetLife 200 Park Avenue New York, NY 10166 (800) 683-5433 <i>www.mymetlife.com</i>	The Non-Affiliated Administrators pay for the cost of this coverage through post-tax contributions.
PRE-TAX PAYMENT	---	Benefits Department Plymouth-Canton Community Schools 454 South Harvey Street Plymouth, MI 48170 (734) 416-4834	You pay certain Benefit Contributions on a pre-tax basis through this Benefit Program.
UHCRA	Self-funded	Meritain Health 2370 Science Parkway Okemos, MI 48864 (800) 748-0003 <i>www.mymeritian.com</i>	You decide how much, if any, you want to contribute on a pre-tax basis to your Health Care Account.
DFSA	---	Meritain Health 2370 Science Parkway Okemos, MI 48864 (800) 748-0003 <i>www.mymeritian.com</i>	You decide how much, if any, you want to contribute on a pre-tax basis to your Dependent Care Account.

*You are always responsible for any Benefit Program Coinsurance, Copayments or Deductibles.

APPENDIX C

CLAIMS SUBMISSION AND APPEAL INFORMATION

BENEFIT PROGRAM	TYPE OF CLAIM/APPEAL	CLAIMS ADMINISTRATOR FOR CLAIMS AND APPEALS
MEDICAL	<p><u>Filing a Claim:</u></p> <ul style="list-style-type: none"> • Urgent Care Claims: • Pre-Service and Concurrent Care Claims: • Post-Service Claim: • Prescription drug (out of network) Claim: <p><u>Review of Denied Claim:</u> This Benefit Program has two required levels of review.</p> <ul style="list-style-type: none"> • First Level: • Second Level: 	<p>Blue Cross Blue Shield of Michigan (BCBSM) P. O. Box 2888 Detroit, MI 48231 800.637-2227</p> <p>Blue Cross Blue Shield of Michigan (BCBSM) P. O. Box 2888 Detroit, MI 48231 800.637-2227</p> <p>Blue Cross Blue Shield of Michigan (BCBSM) P. O. Box 2888 Detroit, MI 48231 800.637-2227</p> <p>Blue Cross Blue Shield of Michigan (BCBSM) P. O. Box 2888 Detroit, MI 48231 800.637-2227</p> <p>Medco Health Solutions P. O. Box 14711 Lexington, KY 40512 800.778.0735</p> <p>Send your request to the address found at the top right hand corner of the first page of your BCBSM Explanation of Benefits</p> <p>Blue Cross Blue Shield of Michigan Level 2 Appeals Unit 600 Lafayette East, #1605 Detroit, MI 48226-2998 888.869.5383</p>

APPENDIX C

CLAIMS SUBMISSION AND APPEAL INFORMATION

BENEFIT PROGRAM	TYPE OF CLAIM/APPEAL	CLAIMS ADMINISTRATOR FOR CLAIMS AND APPEALS
DENTAL	<p><u>Filing a Claim:</u></p> <p><u>Review of Denied Claim:</u> This Benefit Program has one required level of review.</p>	<p>Delta Dental of Michigan P.O. Box 9085 Farmington Hills, MI 48333-9085 (800) 524-0149</p> <p>Delta Dental of Michigan Attn: Customer Service P.O. Box 30416 Lansing, MI 48909-7916 (800) 524-0149</p>
DENTAL	<p><u>Filing a Claim:</u></p> <p><u>Review of Denied Claim:</u> This Benefit Program has one required level of review.</p>	<p>ADN Meritain Health P.O. Box 610 Southfield, MI 48037-0610 800-748-0003, ext. 5</p> <p>ADN Meritain Health P.O. Box 610 Southfield, MI 48037-0610 800-748-0003, ext. 5</p>
VISION	<p><u>Filing a Claim:</u></p> <p><u>Review of Denied Claim:</u> This Benefit Program has one required level of review.</p>	<p>Paper Claims Submission: Meritain Health P.O. Box 853921 Richardson, TX 75085-3921 800-748-0003, ext. 5 Electronic Claims Submission: ENVOY/NEIC, Payor ID: 38232</p> <p>Paper Claims Submission: Meritain Health P.O. Box 853921 Richardson, TX 75085-3921 800-748-0003, ext. 5 Electronic Claims Submission: ENVOY/NEIC, Payor ID: 38232</p>

APPENDIX C

CLAIMS SUBMISSION AND APPEAL INFORMATION

BENEFIT PROGRAM	TYPE OF CLAIM/APPEAL	CLAIMS ADMINISTRATOR FOR CLAIMS AND APPEALS
LTD	<p><u>Filing a Claim:</u></p> <p><u>Review of a Denied Claim:</u> This Benefit Program has one required level of review.</p>	<p>Submit the Claim to:</p> <p>Benefits Department Plymouth-Canton Community Schools 454 South Harvey Street Plymouth, MI 48170 (734) 416-4834</p> <p>The Benefits Department will forward your Claim to:</p> <p>CIGNA Group Insurance Intake Service Center 1225 Greenville, #100 Dallas, TX 75243 (800) 642-8553</p> <p>CIGNA Group Insurance Intake Service Center 1225 Greenville, #100 Dallas, TX 75243 (800) 642-8553</p>
VOLUNTARY LTD	<p><u>Filing a Claim:</u></p> <p><u>Review of a Denied Claim:</u> This Benefit Program has one required level of review. Claim # is required.</p>	<p>Submit the Claim to:</p> <p>Benefits Department Plymouth-Canton Community Schools 454 South Harvey Street Plymouth, MI 48170 (734) 416-4834</p> <p>The Benefits Department will forward your Claim to:</p> <p>MetLife Disability Unit P.O. Box 14590 Lexington, KY 40511 (800) 300-4296</p> <p>MetLife Disability Unit P.O. Box 14590 Lexington, KY 40511 (800) 300-4296 Fax (866) 690-1264 or (800) 230-9531</p>

APPENDIX C

CLAIMS SUBMISSION AND APPEAL INFORMATION

BENEFIT PROGRAM	TYPE OF CLAIM/APPEAL	CLAIMS ADMINISTRATOR FOR CLAIMS AND APPEALS
LIFE/AD&D INSURANCE	<p><u>Filing a Claim:</u></p> <p><u>Review of Denied Claim:</u> This Benefit Program has one required level of review.</p>	<p>Submit the Claim to:</p> <p>Benefits Department Plymouth-Canton Community Schools 454 South Harvey Street Plymouth, MI 48170 (734) 416-4834</p> <p>The Benefits Department will forward your Claim to:</p> <p>CIGNA Group Insurance Intake Service Center 1225 Greenville, #100 Dallas, TX 75243 (800) 642-8553</p> <p>CIGNA Group Insurance Intake Service Center 1225 Greenville, #100 Dallas, TX 75243 (800) 642-8553</p>
VOLUNTARY LIFE	<p><u>Filing a Claim:</u></p>	<p>Submit the Claim to:</p> <p>Benefits Department Plymouth-Canton Community Schools 454 South Harvey Street Plymouth, MI 48170 (734) 416-4834</p> <p>The Benefits Department will forward your Claim to:</p> <p>MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100 (800) 638-6420</p>

APPENDIX C

CLAIMS SUBMISSION AND APPEAL INFORMATION

BENEFIT PROGRAM	TYPE OF CLAIM/APPEAL	CLAIMS ADMINISTRATOR FOR CLAIMS AND APPEALS
PRE-TAX PAYMENT	<u>Filing a Claim:</u>	Submit the Claim to: Benefits Department Plymouth-Canton Community Schools 454 South Harvey Street Plymouth, MI 48170 (734) 416-4834
DFSA	<u>Filing a Claim:</u> <u>Review of Denied Claim:</u> This Benefit Program has one required level of review.	Meritain Health 2370 Science Parkway Okemos, MI 48864 Submit the Appeal to: Meritain Health 2370 Science Parkway Okemos, MI 48864 To file by fax: 888-837-3725 For a final determination, Meritain Health will forward your Appeal to: Benefits Department Plymouth-Canton Community Schools 454 South Harvey Street Plymouth, MI 48170 (734) 416-4834
UHCRA	<u>Filing a Claim:</u> <u>Review of Denied Claim:</u> This Benefit Program has one required level of review.	Meritain Health 2370 Science Parkway Okemos, MI 48864 Submit the Appeal to: Meritain Health 2370 Science Parkway Okemos, MI 48864 To file by fax: 888-837-3725 For a final determination, Meritain, Inc. will forward your Appeal to: Benefits Department Plymouth-Canton Community Schools 454 South Harvey Street Plymouth, MI 48170 (734) 416-4834

APPENDIX D

PLAN WORKFORCE FOR HIPAA PRIVACY RULE

- Plymouth-Canton Community Schools Assistant Superintendent for Business Services
- Plymouth-Canton Community Schools Executive Director of Human Resources
- Plymouth-Canton Community Schools Employee Benefits Coordinator
- Plymouth-Canton Community Schools Director Integrated Technology Systems
- Plymouth-Canton Community Schools Director of Finance