

**AMENDMENT TO PLYMOUTH-CANTON COMMUNITY SCHOOLS
EMPLOYEE BENEFIT PLAN DOCUMENT
AND SUMMARY PLAN DESCRIPTION**

THIS AMENDMENT to the Plymouth-Canton Community Schools Employee Benefit Plan Document and Summary Plan Description (the "Plan") is entered into by Plymouth-Canton Community Schools, a Michigan public school district (the "School District").

WHEREAS, the School District entered into the Plan effective January 1, 2008 and restated effective September 1, 2010; and

WHEREAS, pursuant to the Patient Protection and Affordable Care Act ("PPACA") and Internal Revenue Service Notice 2010-59, certain amendments to the Plan are required to be undertaken by the School District in order to comply with current law; and

WHEREAS, the School District desires to modify certain terms of the Plan due to changes in Applicable Law;

NOW THEREFORE, the School District hereby amends the Plan as follows:

1. Dependents. Upon execution of this Amendment, page 6 under the caption "Dependent Eligibility" of the Plan is deleted and replaced with the following:

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 Medical, Dental and Vision Benefit Programs is:

- Your Spouse, unless legally separated.
- Your Child until the day in which they turn 26 years of age.
- Your Child of any age who meets all of the following requirements:
 - the Child was totally and permanently disabled before age 26 and you notify the Plan Administrator in writing of the condition within 31 days of the date your Child turns age 26,
 - 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, Dental and Vision 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. Failure to notify the Plan Administrator that a dependent is no longer eligible for coverage is considered an intentional misrepresentation of material fact entitling the Plan to rescind the dependent's coverage. 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.

Children whose coverage ended (or were not enrolled) because of an age will have a special enrollment right when the group health plan is changed to provide coverage until the Child's 26th birthday. These adult children must be given a notice and at least 30 days to enroll and permitted to select from the available options.

"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 26 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 will 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.

2. W-2 Reporting. Upon execution of this Amendment, the following paragraph is added to page 73 under the caption "Compliance with Tax Law":

The Patient Protection and Affordable Care Act requires that beginning with the 2011 tax year, the District must report the value of employer-sponsored health care coverage on the employee's W-2 form. However, the Internal Revenue Service has deferred mandatory reporting until 2012. Reporting may be done in 2011 using code DD in Box 12 on a voluntary basis. The amount reportable is for informational purposes; it is not taxable and should not be included in taxable compensation which is reported in Box 1. The value shall be calculated using the COBRA cost of coverage (minus 2%) and include the cost for major medical, prescription drug, EAP, and any health care flexible-spending account contributions other than salary reduction. Stand-alone dental and vision plan costs do not need to be included. The cost of dental or vision packaged with medical must be included.

3. Rescission. Upon execution of this Amendment, the following bullet point is added on page 15 under the caption "End of Participation in the Plan":

- You perform an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of a material fact. Such rescission is defined as the retroactive cancellation or discontinuation of coverage.

4. Internal Claims and Appeals. Upon execution of this Amendment, the following paragraph is added on page 54 under "Procedures for All Benefit Programs":

With respect to internal claims and appeals processes for individual health insurance coverage, issuers must initially incorporate the internal claims and appeals processes set forth in applicable State law and update such processes in accordance with standards established by the Secretary of the Department of Health and Human Services. The July 2010 regulations issued by the Departments of Health and Human Services, Department of Labor, and the Michigan Treasury Department provided updated standards for internal claims and appeals processes:

- (1) The scope of adverse benefit determinations eligible for internal claims and appeals includes a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time).
- (2) Health insurance issuers offering individual health insurance coverage are permitted only one level of internal appeal.
- (3) Health insurance issuers offering individual health insurance coverage must maintain all records of claims and notices associated with internal claims and appeals for six (6) years and must make these records available for examination by the claimant, State or Federal oversight agency.

The District shall provide the claimant (free of charge) with new or additional evidence considered, relied upon, or generated by (or at the direction of) the plan or issuer in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the claimant to respond to such new evidence or rationale. Additionally, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, must not be based upon the likelihood that the individual will support the denial of benefits.

The District shall provide notices to claimants in a culturally and linguistically appropriate manner and shall provide the following additional content:

- (a) Any notice of an adverse benefit determination or final internal adverse benefit determination shall include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
- (b) The District shall ensure that the reason or reasons for an adverse benefit determination or final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the plan's or issuer's standard, if any, that was used in denying the claim. In the case of a final internal adverse benefit determination, this description shall also include a discussion of the decision.
- (c) The District shall provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
- (d) The District shall disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

5. External Review. Upon execution of this Amendment, the following paragraph is added on page 54 under "Procedures for All Benefit Programs" and below the aforementioned Section 4 of this Amendment:

Any violation of the procedural rules of the July 2010 regulations pertaining to internal claims and appeals would permit a claimant to seek immediate external review or court action, as applicable, unless the violation was:

- (1) De minimis;
- (2) Non-prejudicial;

- (3) Attributable to good cause or matters beyond the Plan's or District's control;
- (4) In the context of an ongoing good-faith exchange of information; and
- (5) Not reflective of a pattern or practice of non-compliance.

Additionally, the claimant shall be entitled, upon written request, to an explanation of the Plan's or District's basis for asserting that it meets this standard, so that the claimant could make an informed judgment about whether to seek immediate review. If the external reviewer or the court rejects the claimant's request for immediate review on the basis that the Plan met this standard, this amendment would give the claimant the right to re-submit and pursue the internal appeal of the claim.

Before January 1, 2012, an applicable State external process will apply in lieu of the requirements of the Federal external review process. PHS Act section 2719(c) authorizes the Departments to deem an external review process "in operation as of the date of enactment" of the Patient Protection and Affordable Care Act as compliant with the external review requirements of PHS Act section 2719(b). Through December 31, 2011, any currently effective State external review process satisfies the requirements of either PHS Act section 2719(c) or section 2719(b)(2). If there is no applicable State external review process, the District shall choose between the HHS-administered process or the private accredited IRO process.

6. Lost Eligibility. Upon execution of this Amendment, the following language is added on page 10 under the heading "Special Enrollment Period":

"Lost Eligibility for Other Coverage" means a loss of other health coverage as a result of your legal separation or divorce, a dependent's loss of dependent status, death, termination of employment or reduction in number of hours of employment, or meeting or exceeding a lifetime limit on health benefits under another plan.

7. Change Event. Upon execution of this Amendment, the following language is added on page 14 under the heading "Qualified Change in Status Events":

The Change Event must cause you or your Eligible Dependents to gain or lose coverage under this Plan or another Group Health Plan and your election changes must be consistent with the Life Event.

8. HIPAA Privacy and Security Rules. Upon execution of this Amendment, the following language is added on page 27 under the heading "HIPAA Privacy and Security Rules" and the sub-heading "Required Disclosures of PHI by the Plan:

However, federal law prohibits the Plan from using or disclosing PHI that is genetic information (e.g., family medical history) for underwriting purposes, which include eligibility determinations, calculating premiums, applications of any pre-existing condition exclusions and any other activities related to the creation, renewal, or replacement of a health insurance contract or health benefits.

9. Fraud and Abuse. Upon execution of this Amendment, the following language is added on page 78 below under the heading "Other Important Information About This Plan":

► **FRAUDE AND ABUSE**

Knowingly and willfully engaging in fraudulent behavior, including executing, or attempting to execute, a scheme to defraud the Plan, or to obtain by means of false or fraudulent pretenses, any of the money or property owned by or under the control of the Plan, by your or your Eligible Dependent, may result in immediate termination from coverage under the Plan. Additionally, if you or your Eligible Dependents knowingly and willfully falsify, conceal, or cover up any material fact, or make any materially false or fictitious, or fraudulent statements in connection with enrollment in the Plan, or the receipt of health care benefits under the Plan, coverage under the Plan may be terminated. The Plan Administrator has the right to seek full recovery of any losses from, and to pursue criminal and civil prosecution against any individuals committing fraudulent behavior.

10. Ratification of Amendment and Plan. All other terms, provisions and conditions set forth in the Plan shall remain in full force and effect.

IN WITNESS WHEREOF, Plymouth-Canton Community Schools causes this Amendment to the Plan effective as of September 1, 2011.

PLYMOUTH-CANTON COMMUNITY SCHOOLS

By: Dawn Schaefer

Title: Employee Benefits Coordinator