TEXAS SCHOOLS
HEALTH BENEFITS PROGRAM
AETNA SIGNATURE
COPAY PLAN

Plan Document and Summary Plan Description
Effective: September 1, 2023

INITIAL COBRA NOTIFICATION VERY IMPORTANT NOTICE

It is important that all covered individuals (employee, spouse, and dependent children, if able) take the time to read this notice carefully and be familiar with its contents. If there is a covered dependent whose legal residence is not yours, please provide written notification to your employer so a notice can be sent to them as well.

Under federal COBRA law, your employer is required to offer covered employees and covered family members the opportunity for a temporary extension of health coverage (called "Continuation Coverage") at group rates when coverage under the health plan would otherwise end due to certain qualifying events. This notice is intended to inform you (and your covered dependents, if any), in a summary fashion of your potential future options and obligations under the continuation coverage provisions of the COBRA law. Should an actual qualifying event occur in the future, the plan administrator will send you additional information and the appropriate election notice at that time. Please take special note, however, of your notification obligations which are highlighted at the bottom of this page.

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

Qualifying Events For Covered Employee - If you are the covered employee, you may have the right to elect this health plan continuation coverage if you lose your group health coverage because of a termination of your employment (for reasons other than gross misconduct on your part) or a reduction in your hours of employment.

Qualifying Events For Covered Spouse - If you are the covered spouse of an employee, you may have the right to elect this health plan continuation coverage for yourself if you lose group health coverage under the employer's Employee Benefit Plan because of any of the following reasons:

1. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with the employer;
2. The death of your spouse;
3. Divorce or, if applicable, legal separation from your spouse; or
4. Your spouse becomes entitled to Medicare.

Qualifying Events For Covered Dependent Children - If you are the covered dependent child of an employee, you may have the right to elect continuation coverage for yourself if you lose group health coverage under the employer's Employee Benefit Plan because of any of the following reasons:

1. A termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment with the employer;
2. The death of the employee of the employer;
3. Parent's divorce or, if applicable, legally separated;
4. The employee of your employer becomes entitled to Medicare; or
5. You cease to be a "dependent child" under the terms of the health plan.

Important Employee, Spouse, and Dependent Notifications Required
Under the law, the employee, spouse, or other family member has the responsibility to notify of a divorce, legal separation, or a child losing dependent status under your employer's Employee Benefit Plan. This notification must be made within 60 days from whichever date is later, the date of the event or the date on which health plan coverage would be lost under the terms of the benefit contract because of the event.

Please notify your employer of any changes in family status, dependent status, and address changes.

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Please mail to the following address:

Texas Schools Health Benefits Program
Attn: Plan Administrator
2175 N Glenville Dr,
Richardson, TX 75082

If this notification is not completed according to the above procedures and within the required 60-day notification period, then rights to continuation coverage will be forfeited. Carefully read the dependent eligibility rules contained in the summary plan description so you are all familiar with when a dependent ceases to be a dependent under the terms of the plan. Your employer will notify the Plan Supervisor, 90 Degree Benefits of the employee's termination of employment, reduction in hours, death, or Medicare entitlement.

Election Period And Coverage - Once the plan administrator learns a qualifying event has occurred, the plan administrator will notify covered individuals (also known as qualified beneficiaries) of their rights to elect continuation coverage. Each qualified beneficiary has independent COBRA election rights and will have 60 days to elect continuation coverage. The 60-day election window is measured from the later of the date health plan coverage is lost due to the event or from the date of COBRA notification. This is the maximum period allowed to elect COBRA as the plan does not provide an extension of the election period beyond what is required by law. If a qualified beneficiary does not elect continuation coverage within this election period, then rights to continue health coverage will end and they cease to be a qualified beneficiary.

If a qualified beneficiary elects continuation coverage, they will be required to pay the entire cost for the health coverage, plus a 2% administration fee. Your employer is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the plan to similarly situated non-COBRA participants and/or covered dependents. Should coverage change or be modified for non-COBRA participants, then the change and/or modification will be made to your coverage as well.

Length of Continuation Coverage - 18 Months. If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, then each qualified beneficiary will have the opportunity to continue coverage for 18 months from the date of the qualifying event.

Social Security Disability - The 18 months of continuation coverage can be extended for an additional 11 months of coverage, to a maximum of 29 months, for all qualified beneficiaries if the Social Security Administration determines a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act on the date of the qualifying event or at any time during the first 60 days of continuation coverage. In the case of a newborn or adopted child that is added to a covered employee's COBRA coverage, then the first 60 days of continuation coverage for the newborn or adopted child is measured from the date of the birth or the date of the adoption. It is the qualified beneficiary’s responsibility to obtain this disability determination from the Social Security Administration and provide a copy of the determination to the Employer within 60 days after the date of determination and before the original 18 months expire.

This extension applies separately to each qualified beneficiary. If the disabled qualified beneficiary chooses not to continue coverage, all other qualified beneficiaries are still eligible for the extension. If coverage is extended, and the disabled qualified beneficiary has elected the extension, then the applicable contribution rate is 150% of the contribution rate. If only the non-disabled qualified beneficiaries extend coverage, the contribution rate will remain at the 102% level. It is also the qualified beneficiary’s responsibility to notify your employer within 30 days if a final determination has been made that they are no longer disabled.

Secondary Events - Another extension of the 18 or above mentioned 29-month continuation period can occur, if during the 18 or 29 months of continuation coverage, a second event takes place (divorce, legal

separation, death, Medicare entitlement, or a dependent child ceasing to be a dependent). If a second event occurs, then the original 18 or 29 months of continuation coverage can be extended to 36 months from the date of the original qualifying event date for eligible dependent qualified beneficiaries. If a second event occurs, it is the qualified beneficiary's responsibility to notify your employer in writing within 60 days of the second event and within the original 18 or 29-month COBRA timeline. In no event, however, will continuation coverage last beyond three years from the date of the event that originally made the qualified beneficiary eligible for continuation coverage. A reduction in hours followed by a termination of employment is not considered a second event for COBRA purposes.

Length of Continuation Coverage - 36 Months. If the original event causing the loss of coverage was the death of the employee, divorce, legal separation, Medicare entitlement, or a dependent child ceasing to be a dependent child under your Employee Benefit Plan, then each qualified beneficiary will have the opportunity to continue coverage for 36 months from the date of the qualifying event.

Eligibility, Contributions, And Potential Conversion Rights - A qualified beneficiary does not have to show they are insurable to elect continuation coverage, however, they must have been actually covered by the plan on the day before the event to be eligible for COBRA continuation coverage. An exception to this rule is if while on continuation coverage a baby is born to or adopted by a covered employee qualified beneficiary. If this occurs, the newborn or adopted child can be added to the plan and will gain the rights of all other qualified beneficiaries. The COBRA timeline for the newborn or adopted child is measured from the date of the original qualifying event. Procedures and timelines for adding these individuals can be found in your benefits booklets and must be followed. The plan administrator reserves the right to verify COBRA eligibility status and terminate continuation coverage retroactively if you are determined to be ineligible or if there has been a material misrepresentation of the facts.

A qualified beneficiary will have to pay all of the applicable contributions plus a 2% administration charge for continuation coverage. These contributions will be adjusted during the continuation period if the applicable contribution amount changes. In addition, if continuation coverage is extended from 18 months to 29 months due to a Social Security disability, the Employer can charge up to 150% of the applicable contributions during the extended coverage period. Qualified beneficiaries will be allowed to pay on a monthly basis. In addition, there will be a maximum grace period of (30) days for the regularly scheduled monthly contributions. At the end of the 18, 29, or 36 months of continuation coverage, a qualified beneficiary must be allowed to enroll in an individual conversion health plan provided under your employer if an individual conversion plan is available at that time.

Cancellation Of Continuation Coverage - The law provides COBRA continuation coverage will end prior to the maximum continuation period for any of the following reasons:

1. Your employer ceases to provide any group health plan to any of its employees;
2. Any required contributions for continuation coverage are not paid in a timely manner;
3. A qualified beneficiary first becomes, after the date of COBRA election, entitled to Medicare;
4. A qualified beneficiary extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled;
5. A qualified beneficiary notifies your employer they wish to cancel COBRA continuation coverage.
6. For cause, on the same basis that the plan terminates the coverage of similarly situated non-COBRA participants.

Other coverage options besides COBRA Continuation Coverage may be available. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Notification of Address Change - To ensure all covered individuals receive information properly and efficiently, it is important you notify your employer of any address change as soon as possible. Failure on your part to do so will result in delayed COBRA notifications or a loss of continuation coverage options.

Any Questions? - Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights, including COBRA, the Affordable Care Act (ACA), 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 (EBSA) in your area or visit https://www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

90 Degree Benefits
Attn: COBRA Department
11467 Huebner Rd.
Suite 300
San Antonio, Texas 78230

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ARTICLE I - ESTABLISHMENT OF THE PLAN

ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Texas Schools Health Benefits Program (the "Company" or the "Plan Sponsor") as of September 1, 2023, hereby sets forth the provisions of the Texas Schools Health Benefits Program – Aetna Signature Copay Plan (the "Plan"). Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

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

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

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

Texas Schools Health Benefits Program – Aetna Signature Copay Plan

By: Russ Edwards

Name: Russ Edwards

Date: September 25, 2023

Title TSHBP Program Administrator

ARTICLE II - INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose
The Plan Sponsor has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Plan benefits are self-funded through a benefit fund, or a trust established by the Plan Sponsor with contributions from Participants and/or the Plan Sponsor. Participants in the Plan may be required to contribute toward their benefits. Contributions received from Participants are used to cover Plan costs and are expended immediately.

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

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

General Plan Information Affordable Care Act (ACA)
This group health plan believes this plan is **not** a "grandfathered health plan" under Health Care reform. Questions regarding the Plan's status can be directed to the Plan Administrator at the following address:

Texas Schools Health Benefits Program
Attn: Plan Administrator
2175 N Glenville Dr,
Richardson, TX 75082

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

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

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

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

Mental Health Parity
Pursuant to the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

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

Applicable Law
This Plan is a governmental (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a federal law regulating Employee welfare and pension plans. The Participants' rights in the Plan are governed by the plan documents and applicable State law and regulations. This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, Exclusions, or limitations. Additionally, the Plan will comply with any applicable State PPO prompt pay laws.

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

Definitions
Words and phrases appearing in initial capital letters are defined terms. The complete definitions can be found in the Definitions section that appears at the end of this document.

ARTICLE III - SUMMARY OF BENEFITS

General Limits
Payment for any of the expenses listed below is subject to all Plan exclusions, limitations, and provisions. All coverage figures are after Deductible and Copayment requirements have been satisfied, unless otherwise specified.

Health Provider Categories
The Plan contracts with the medical Provider Networks to access discounted fees for service for Participants. Hospitals, Physicians, and other Providers who have contracted with the medical Provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "Non-Network Providers."

In most instances, benefits are available for services only when they are received from Network Providers. Because Network Healthcare Providers have agreed to charge reduced fees to Participant under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Please refer to the Medical Benefits Schedule for detailed information on coverage levels for Network Healthcare Providers under this Plan.

In such an instance where a Non-Network Healthcare Providers is used and coverage is available, the Participant may have substantial additional costs for which they are responsible because the Plan pays Non- Network Healthcare Providers based on the Maximum Allowable Charge. In addition to cost sharing amounts, the Participant will also be responsible for any charges above the Maximum Allowable Charge when receiving covered services from a Non-Network Provider. Therefore, the percentage of payment actually paid by this Plan may be lower than the stated percentage, and the percentage of payment paid by the Participant may be higher than the stated percentage.

The Plan provides benefits based on whether a Participant uses a Network Provider. Unless one of the exceptions shown below applies, or as otherwise indicated in the Schedule of Benefits, if a Participant elects to receive medical care from a Non-Network Provider, generally, benefits will be unavailable.

1. **Plan Exceptions**: Under the following circumstances, the Network Healthcare Provider benefit level may be available for Non-Network Healthcare Provider's services:

    - Professional services of an emergency room Physician, radiologist, pathologist, anesthesiologist, or hospitalist for services which are rendered at a facility;
    - Services unavailable from a Network Provider;
    - Transition of Care – subject to Plan approval (see page 10); and
    - Continuity of Care (see page 11).

2. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by a Non-Network Provider for any covered service is higher than the Maximum Allowable Charge determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any Provider, at its discretion.

3. To receive benefit consideration, Participants may need to submit claims for services provided by Non-Network Providers to the Third-Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.

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

5. Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

A current list of Participating Providers is available, without charge, at the following website, Aetna Directory tool: http://www.aetna.com/asa. If the Participant does not have access to a computer at home, they may access this website at their place of employment. If there are any questions about how to do this, the Human Relations Department should be contacted. The Participating Provider list changes frequently; therefore, it is recommended that a Participant verify with the Provider that the Provider is still a Participating Provider before receiving services. Please refer to the Participant identification card for the PPO website address.

Enrolling in this Plan does not guarantee that a particular Network Healthcare Provider will remain a Network Healthcare Provider or that a particular Healthcare Provider will provide Participants under this Plan only with Covered Services. Participants should verify a Healthcare Provider's status as a Network Healthcare Provider each time services are received from the Healthcare Provider.

Choice of Providers

The Plan is not intended to disturb the Physician-patient relationship. Each Participant has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other healthcare Providers are not agents or delegates of the Plan Sponsor, Company, Plan Administrator, Employer or Third-Party Administrator.

The delivery of medical and other healthcare services on behalf of any Participant remains the sole prerogative and responsibility of the attending Physician or other healthcare Provider. The Participant, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Plan Administrator, will be eligible for payment.

Transition of Care

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

The Plan shall notify the Participant in a timely manner, but in no event later than 90 calendar days after termination that the Provider's contractual relationship with the Plan has terminated, and that the Participant has rights to elect continued transitional care from the Provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 6 months later or when the Participant ceases to be a continuing care patient, whichever is sooner.

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

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

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

Continuity of Care

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

The Plan shall notify the Participant in a timely manner, but in no event later than 6 months after termination that the Provider's contractual relationship with the Plan has terminated, and that the Participant has rights to elect continued transitional care from the Provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

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

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

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

No Surprises Act – Emergency Services and Surprise Bills

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

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

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

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

Claims Audit

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

The analysis will be employed to identify charges billed in error and/or charges that are not the Maximum Allowable Charge and/or Medically Necessary if any and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

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

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

Balance Billing

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

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

The Participant is responsible for any applicable payment of Deductible, Copayments or Coinsurance requirements, and any amounts applied to the Out-of-Pocket Maximums, and may be billed for any or all of these.

CARECONNECT PROGRAM

CareConnect is a care coordination program that provides consumers with on-line and phone assistance to provide decision support, enabling consumers to become active and informed purchasers of health care. By facilitating pre-negotiated or "cash" payment at the time of service, Participants receive the direct benefits of "cash" discounts from Providers who experience less administrative hassle and avoid the cost of billing, collections, and bad debt. In addition to discounts on medical services, if a Participant chooses to contact the Care Coordinator Program and utilizes the preferred provider option that is recommended for a procedure or an admission to a Facility, the Participant will be eligible to receive up to a $500 credit towards the Plan Year Deductible. If the Plan Year Deductible has been met, the $500 credit* will apply towards the Out-of-Pocket Maximum.

**Note: A smaller credit will apply in instances where the cost of the service option is less than $500 total.*

CareConnect Coordinator Review of Covered Services

The CareConnect Coordinator Review Program is designed to help all Participants receive Medically Necessary health care. Notification can be provided as specified for the non-emergent Inpatient and Outpatient services, as well as other healthcare expenditures as listed on page 13.

In order to utilize this Program, the Participant may contact the CareConnect Coordinator as soon as a procedure is scheduled, or at least (5) five business days prior to non-emergent Inpatient, Outpatient Services, or a Major Diagnostic Procedure, (or as soon as reasonably possible if the Participant has experienced an Emergency or emergent situation). The Coordinator will collaborate with the Plan member to identify their healthcare needs and choose the services that can contribute to improving the quality of care, and at the same time, negotiate with facilities and Providers to contain health care expenditures.

Please note, if the Participant chooses not to utilize the CareConnect Program recommendation, expenses will be eligible for consideration and will be subject to normal Plan provisions, including any other precertification or pre-authorization requirements that apply.

IMPORTANT NOTE

In order to utilize the CareConnect Coordinator Program, CareConnect may be contacted as soon as a procedure is scheduled, or at least (5) five business days prior to non-emergent Inpatient, Outpatient Services, or a Major Diagnostic Procedure, (or as soon as reasonably possible in the event of an Emergency or emergent situation.)

Notification can be made to CareConnect at 1 (888) 803-0081 (toll-free) for the qualifying services as indicated on page 13.

Surgical Services For Which The CareConnect Coordinator Program May Be Used:

- If a Physician recommends Surgery, a Participant may contact the CareConnect Coordinator prior to services being rendered as indicated above. Please note that this Program applies to surgical procedures that are performed on an Inpatient /Outpatient hospital basis, or at an ambulatory surgery facility.
- The Surgical Service Coordination Program DOES NOT apply to expenses incurred for, or in connection with, surgical procedures which are not covered under the Plan, surgical procedures performed in a Physician's office (such as incision and drainage of an abscess or excision of benign lesions), or "Emergent Care Surgical Services" meaning surgical services which, if delayed, could result in disability or death. Please note, if a Participant is admitted as Inpatient on an Emergency basis, compliance with this Plan's pre-certification provisions must be fulfilled as required.

Other Services For Which The CareConnect Coordinator Program May Be Utilized:

If a Physician recommends any of the following, a Participant may contact the CareConnect Coordinator at the number indicted above, prior to services being rendered:

- Chemotherapy / Radiation Therapy,
- Dialysis,
- Durable Medical Equipment,
- Home Health Care,
- Home Infusion Therapy,
- Hospice Care,
- Inpatient confinement,
- Major Diagnostic Procedures (Including, but not limited to: MRI, PET, CT, Myelogram, Cardiac Stress Test, and Bone Scans),
- Prosthetics / Orthotics
- Rehabilitation Services (Cardiac Rehabilitation, Physical, Occupation, Aquatic or Speech Therapies);
- Skilled Nursing Facility confinement, and
- Sleep Studies.

CareConnect Travel Benefit

In addition to the benefits indicated above, this Plan also offers enhanced benefits for Participants when they choose to have certain medical procedures performed by specified Providers or facilities that are not local to their residence. This benefit is made available to Plan participants to encourage utilization of quality Providers at negotiated rates and allows the Plan to offer quality service options at the most reasonable cost.

The travel benefit allows for reimbursement of transportation, lodging, and meals for the patient and one companion (or two companions if the patient is a minor child) if the Participant selects to receive services from a Provider who has agreed to certain arrangements as approved by the Plan. In order to be eligible for this benefit, the Provider or facility chosen must be more than 50 miles from the Participant's home address and must be the closest facility where the service is available. In order to assure coverage, the associated travel expenses must be pre-approved by 90 Degree Benefits, selected Plan vendors or the Plan, prior to such expenses being incurred, regardless of whether the service requires or receives pre-certification. For further information regarding this benefit, please contact 90 Degree Benefits.

Benefits available under this provision are as follows:

- Travel allowances – Travel is paid for between the patient's home and the facility/Provider for round trip (air - coach class only, train, bus, rental car) transportation costs. If traveling by rental car, gas will be reimbursed in addition to the cost of the rental car. If traveling by personal auto, mileage payment is paid based upon the published IRS standard rate for business vehicle usage at the date the claim is incurred in addition to gasoline.

  (Payment rate information is available at: www.irs.gov.)

- Lodging allowances – Payment allowance for the patient and up to one companion for hotel lodging away from home is paid for at a per diem rate of $125 per night when traveling domestically. When traveling internationally, the per diems for both lodging and meals will be determined based upon the location of services. The number of days of lodging will be solely determined by 90 Degree Benefits, select Plan vendors, or the Plan and shall be based on the distance required for travel and length of stay for procedure(s). Any additional approved days, based on need from complications or travel restrictions, will be solely determined by 90 Degree Benefits, select Plan vendors, or the Plan.

- Meal allowance for domestic travel – Payment allowance or the patient and any companion for meals away from home are paid at a rate of $50 per person per day, to include day of travel to location and travel home.

- International travel - If international travel is required, the per diems for both lodging and meals will be determined based upon the location of services.

Note: Benefits are not available for items not directly related to travel, lodging, and meal expenses. These include, but are not limited to, alcoholic beverages, car maintenance, cards, stationery, stamps, clothing, dry-cleaning, entertainment (cable television, books, magazines, movie rentals), sales tax, and flowers.

ARTICLE IV - SCHEDULE OF BENEFITS

Schedule of Medical Benefits – Aetna Signature Copay Plan
The Plan utilizes a Network for Practitioner and Facility claims. In most instances, benefits are available for expenses when incurred from Network Providers only, however in the event that expenses from a Non-Network Provider are eligible under the terms of this Plan, the allowed charges for Non-Network Providers will be based on the Maximum Allowable Charge.

Certain covered services are subject to pre-service authorization and/or pre-certification requirements in order to obtain maximum benefits. Please refer to Article III - Summary of Benefits, and Article IX – Cost Containment for further information regarding specific services, surgeries or other procedures that may require review and details on how to fulfill Plan requirements. Furthermore, if a benefit maximum is listed, it is a combined maximum benefit for the services that the Participant receives from all Network and Non-Network Providers and facilities. Also, please refer to Article VI - Medical Exclusions and Limitations, and Article XIII - General Limitation and Exclusions for information regarding Plan limitations that may also affect benefits.

The following benefits are per Participant per Plan Year (9/1 through 8/31). In addition, all benefits are subject to the Maximum Allowable Charge.

AETNA SIGNATURE COPAY PLAN - SCHEDULE OF BENEFITS ***In most instances, benefits are available for expenses when incurred from Network Providers only, unless otherwise indicated in the Schedule of Benefits, or as specified as a Plan exception.*** ***(Please refer to page 9 for Plan exceptions.)***	
	NETWORK PROVIDERS
LIFETIME /PLAN YEAR - MAXIMUM BENEFIT	**UNLIMITED**
PLAN YEAR DEDUCTIBLE	
• Individual • Family Unit *(cumulative, see below)*	$4,000 $8,000
The Plan Year Family Deductible will be met when members of a Family Unit have reached covered Deductible amounts that equal $8,000 on a cumulative basis, however the amount that each Participant may fulfill will not exceed the $4,000 individual Deductible requirement. Each Plan Year, fulfillment of a new Plan Year Deductible amount is required.	
PLAN YEAR OUT-OF-POCKET MAXIMUM	
• Individual • Family Unit *(cumulative, see below)*	$9,100 $18,200
The Plan Year Out-of-Pocket Maximum includes Medical and Prescription Drug Deductible, Copayment, and Coinsurance amounts, (except as otherwise specified). The Plan Year Family Unit Out-of-Pocket Maximum will be met when members of a Family Unit have reached covered Out-of-Pocket expenses that equal $18,200, however the amount that each Participant may fulfill will not exceed the $9,100 individual Out-of-Pocket Maximum requirement. Once the individual or Family Out-of-Pocket Maximum has been met, eligible expenses will be covered at 100% of the allowed amount for the remainder of that Plan Year. *Each Plan Year, fulfillment of a new Out-of-Pocket Maximum is required. However, expenses incurred for services that are not covered under the Plan, charges which exceed the Maximum Allowable Charge, costs paid by the covered individual as a result of failure to comply with pre-authorization requirements, the Surgeon's copayment requirement for bariatric surgery, and charges in excess of applicable Plan maximums will not apply to fulfill this requirement.*	

AETNA SIGNATURE COPAY PLAN - SCHEDULE OF BENEFITS (Continued) ***In most instances, benefits are available for expenses when incurred from Network Providers only, unless otherwise indicated in the Schedule of Benefits, or as specified as a Plan exception.*** ***(Please refer to page 9 for Plan exceptions.)***	
BENEFITS	**NETWORK PROVIDERS**
	(Benefit Percentages - What the Plan Pays)
Ambulance Expenses ***Note: The benefits that are indicated for this expense apply to charges incurred from either a Network or Non-Network Provider.***	70%, after Deductible
Ambulatory Surgical Center / Outpatient Surgery Facility Expenses	70%, after Deductible
Anesthesia Services *(All places of services, including Dr.'s office, Outpatient Hospital, etc.)*	70%, after Deductible
Bariatric Surgery – *Surgeon's Expense* • Maximum Benefit	$5,000 Copay per surgery, then 70%, after Deductible *(Note: $5,000 Copay does not apply to the Out-of-Pocket Maximum)* One surgical procedure, per lifetime *(Benefit maximum includes surgical revision to any previous bariatric procedure)*
Cardiac, Pulmonary Rehabilitation, Applied Behavior Analysis and All Other Covered Therapies Not Otherwise Specified *(Outpatient)* *(One Copay per day will apply to either the facility or professional expense, based on the place that the services are rendered and the billing received.)*	$45 Copay per Provider, per day, then 100%, Deductible waived
Chemotherapy / Radiation Therapy *(Outpatient)*	70%, after Deductible
Chiropractic Treatment • Maximum Benefit	$70 Copay per Provider, per day, 100%, Deductible waived 20 visits per Plan Year

AETNA SIGNATURE COPAY PLAN - SCHEDULE OF BENEFITS (Continued) ***In most instances, benefits are available for expenses when incurred from Network Providers only, unless otherwise indicated in the Schedule of Benefits, or as specified as a Plan exception.*** ***(Please refer to page 9 for Plan exceptions.)***	
BENEFITS	**NETWORK PROVIDERS**
	(Benefit Percentages - What the Plan Pays)
Cochlear Implantable Hearing Device *(Cochlear device, external hardware, and related supplies, limited to Participants up to age 19)* • Maximum Benefit	70%, after Deductible One cochlear implant per hearing-impaired ear, every three years, including replacements as Medically Necessary
Dialysis Services & Treatment	70%, after Deductible
Durable Medical Equipment /Durable Medical Equipment Supplies	70%, after Deductible
Emergency Room Treatment *(facility / professional)* *(Copay applies to facility fee only, and will be waived if admitted as Inpatient within 24-hours of Emergency Room visit.)* ***Note: The benefits that are indicated for this expense apply to charges incurred from either a Network or Non-Network Provider.***	$500 Copay per visit, then 70%, after Deductible
Hearing Aids *(for Participants ages 19 and over)* • Maximum Benefit	70%, after Deductible $1,000 per 36 months *(combined benefit, both ears)*
Home Health Care Expenses *(agency / professional expenses)* • Maximum Benefit	70%, after Deductible 60 visits per Plan Year

AETNA SIGNATURE COPAY PLAN - SCHEDULE OF BENEFITS (Continued) ***In most instances, benefits are available for expenses when incurred from Network Providers only, unless otherwise indicated in the Schedule of Benefits, or as specified as a Plan exception.*** ***(Please refer to page 9 for Plan exceptions.)***	
BENEFITS	**NETWORK PROVIDERS**
	(Benefit Percentages - What the Plan Pays)
Hospice Care Expenses *(facility / professional expense, includes Bereavement Counseling)*	70%, after Deductible
Independent Laboratory Services *(facility / professional expenses)*	100%, Deductible waived
Infusion Therapy	70%, after Deductible
Inpatient Hospital Expenses *(facility / professional)*	70%, after Deductible
Maternity Global Expense* *(Physician fee for pre-natal and post-natal care and maternity surgery. See also "Physician Office / Walk-in Clinic Visit" for benefits related to the initial Physician's office visit charges to confirm pregnancy.)* *As mandated by the Affordable Care Act, certain routine prenatal care services will be considered under the Preventive Care benefit provisions.*	70%, after Deductible
Newborn Inpatient Hospital Expenses* *Benefit includes Inpatient Hospital nursery charges and pediatric care to date of baby's discharge.*	70%, after Deductible
Outpatient Hospital Expenses *(facility / professional, unless otherwise specified)*	70%, after Deductible
Outpatient Lab, X-ray, Ultrasounds and Diagnostic Testing – facility / professional expenses *(does not include Major Diagnostic Procedures - see below for benefits)*	70%, after Deductible

AETNA SIGNATURE COPAY PLAN - SCHEDULE OF BENEFITS (Continued) ***In most instances, benefits are available for expenses when incurred from Network Providers only, unless otherwise indicated in the Schedule of Benefits, or as specified as a Plan exception.*** ***(Please refer to page 9 for Plan exceptions.)***	
BENEFITS	**NETWORK PROVIDERS**
	(Benefit Percentages - What the Plan Pays)
Outpatient Major Diagnostic Procedures (*Including, but not limited to, MRI, PET, CT, Nuclear Medicine, Myelogram, Cardiac Stress Test, and Bone Scans, facility/professional expenses, all Outpatient, and office places of service.)*	70%, after Deductible
Outpatient Rehabilitative Therapy Facility / Professional Expenses *(Physical Therapy, Aquatic Therapy, Occupational Therapy, Speech Therapy, and all Other Covered Therapies)* *(One Copay per day will apply to either the facility or professional expense, based on the place that the services are rendered and the billing received.)*	$45 Copay per Provider, per day, then 100%, Deductible waived
Physician Office / Walk-in Clinic Visit • *Office exam, clinic visit, lab, x-ray, certain diagnostic testing (excludes Major Diagnostic Procedures), therapeutic injections, allergy injections, allergy serum, allergy testing, psychotherapy, second surgical opinion consultation, and all other covered services not otherwise specified.* • *Office Surgery, Major Diagnostic Procedures (including, but not limited to, MRI, PET, CT, Nuclear Medicine, Myelogram, Cardiac Stress Test, and Bone Scans.)*	<u>Primary Care Physician (PCP)</u> – $45 Copay per Provider, per day, *or* <u>Specialist</u> - $70 Copay per Provider, per day, then 100%, Deductible waived 70%, after Deductible
Preventive Care Services – Adult / Child Wellness *(Includes Preventive Care Services as mandated by the Affordable Care Act, and other services identified and billed as routine or part of a routine physical exam. Please refer to Covered Medical Benefits for further information.)*	100%, Deductible waived
Prosthetics / Orthotics	70%, after Deductible

AETNA SIGNATURE COPAY PLAN - SCHEDULE OF BENEFITS (Continued) ***In most instances, benefits are available for expenses when incurred from Network Providers only, unless otherwise indicated in the Schedule of Benefits, or as specified as a Plan exception.*** ***(Please refer to page 9 for Plan exceptions.)***	
BENEFITS	**NETWORK PROVIDERS**
	(Benefit Percentages - What the Plan Pays)
Residential Inpatient Treatment Center / Partial Hospitalization Expenses *(Mental Nervous / Substance Abuse)*	70%, after Deductible
Skilled Nursing Facility Expenses • Maximum Benefit	70%, after Deductible Limited to 60 days per Plan Year
Smoking Cessation *(Services and/or supplies as required by the Affordable Care Act)*	100%, Deductible waived
Surgeon / Assistant Surgeon / Co-Surgeon	70%, after Deductible
Urgent Care Services - Walk-in or Hospital-Based Facility *(facility / professional expenses)* *(One Copay per day will apply to either the facility or professional expense, based on the place that the services are rendered and the billing received.)*	$75 Copay per Provider, per day, then 100%, Deductible waived
Wig / Hairpiece • Maximum Benefit	70%, after Deductible 1 per Plan Year, up to $500
All Other Covered Expenses *(facility / professional, unless otherwise specified)*	70%, after Deductible

Schedule of Prescription Drug Benefits - The following benefits are per Participant:

AETNA SIGNATURE COPAY PLAN – PRESCRIPTION DRUG BENEFITS – provided by Liviniti *(Southern Scripts)*		
PRESCRIPTION DRUG PLAN YEAR DEDUCTIBLE		$500 per individual
Tier Level	**Retail Pharmacy - 30-day supply**	**Mail Order- 90-day supply**
	(What the Plan pays, per prescription / refill)	
• *Generic Copay*	$15 Copay, then 100%, Deductible waived	$45 Copay, then 100%, Deductible waived
• *Preferred Brand Name Copay*	75%, after Deductible	75%, after Deductible
• *Non-Preferred Brand Name Copay*	50%, after Deductible	50%, after Deductible
• *Specialty Drugs* *The associated Specialty Drug list for the purpose of this Plan is the Liviniti (Southern Scripts) Standard Specialty Drug List*	50%, after Deductible *(Participation in the RxCompass drug program is mandatory. Please see below for further information.)*	*Not Applicable* *(All Specialty Drug medications are limited to a 30-day supply)*

IMPORTANT NOTES:

1.) *Benefits for prescription drugs will be subject to the Prescription Drug Plan Year Deductible as stated above, except as otherwise specified. Once this Deductible has been satisfied, benefits for prescription drugs will be available, subject to the applicable Copayment and Coinsurance requirements as indicated in the above Schedule.*

2.) *The Participant's Deductible, Copayment and Coinsurance requirements will apply to the Medical Plan's Out-of-Pocket Maximum. Once this has been met, covered prescriptions will be reimbursed at 100% for the remainder of that Plan Year.*

3.) *Specialty Drugs are a narrowly defined class of extremely high-cost, biologic drugs that often require special handling, administration, and careful adherence to treatment protocols. The associated Specialty Drug list for this purpose is the Liviniti (Southern Scripts) Standard Specialty Drug List which contains the drugs by GPI identification. The Specialty Drug list will include both brand and generic therapies and will also include both RX Compass and non-RxCompass drugs. The RX Compass list is separate from the Liviniti (Southern Scripts) Specialty Drug List. Specialty Drugs are not covered by the Medical Plan and as such the Texas Schools Health Benefits Program has engaged RxCompass to assist members with securing drug coupons, manufacturer rebates, and governmental finance assistance as needed. Please refer to the following website for further information:*

Pharmaceutical Drug Look-up tool: https://member.southernscripts.net.

Participation in the RXCompass Drug Program is mandatory; however, while other payment assistance for Specialty Drugs is being sought, Participants may receive coverage through the Medical Reimbursement Plan (MERP) for up to (3) three, 30-day fills while RX Compass is attempting to secure benefit availability. Thereafter, if payment assistance is not obtained, or for any medication for which assistance is unavailable or those medications otherwise disallowed for participation, the Specialty Drug may then be eligible for coverage under the Medical Expense Reimbursement Plan (MERP), subject to all Plan provisions. For any medication covered under the MERP, such expense will be subject to fulfilling the applicable cost-sharing requirements as stated above. In addition, any cost-sharing amounts fulfilled under the MERP will also be applied towards fulfilling requirements under the Medical Plan. All accumulated dollars cross apply.

Note: In the event a Participant refuses to participate in the Payment Assistance Program (PAP) or does not utilize any available payment assistance that is secured, coverage for such medication will not be eligible for reimbursement under the MERP or Medical Plan.

(See Next page for additional "IMPORTANT NOTES" regarding the Prescription Drug Program.)

IMPORTANT NOTES (Continued)

4.) *For the retail benefit, if a Participant prefers to purchase a preferred brand name medication when a generic is available, or if the generic is available and allowed by the Physician, in addition to the brand name Copay, the Participant will also have to pay the difference in cost between the brand name and generic medication. (This amount does not apply to the Copayment Maximum.)*

5.) *Benefits will be payable for the purchase of one 30-day supply of medication through the retail benefit for the Copayment amounts indicated above. Up to a 90-day supply of medication can be purchased through participating retail pharmacies, however a separate copay will apply for each 30-day supply.*

6.) *This Plan is subject to the Affordable Care Act (ACA) which requires the coverage of a number of preventive medications at 100% and ensures these items and services are not subject to Copayments or other limitations such as annual caps or limits. Please contact Liviniti (Southern Scripts) for additional information.*

7.) *Step Therapy is a program that also encourages quality, safe, and reasonably priced prescription drug use. It requires members to try initially preferred, medically proven, and less expensive prescription drugs before "stepping up" to more expensive medications. This program helps make prescription drugs more affordable and saves dollars for both the member and the Plan. Liviniti (Southern Scripts) will review drug history to determine if a Participant has tried the preferred alternatives first. If the prescribed drug does not meet the step therapy criteria, it may not be covered. Prior authorization is required if the Participant and/or Provider believe the step therapy process is not appropriate for the health condition.*

8.) *Per Texas Bill 827, the Participant's share for the cost for insulin will be limited to the following maximums:*

- *1-30 day's supply -$25;*
- *31-60 day's supply - $50; and*
- *61-90 day's supply - $75.*

TELADOC **VIRTUAL TELEHEALTH VISITS**	
Benefit	**(What the Participant pays, per visit)**
• Physician Services *(Medical and Behavioral/Mental Health)*	$0

Through the use Teladoc, a medical service that uses telephone and videoconferencing technology to provide remote medical care via mobile devices, the internet, video, and phone, Teladoc provides remote medical assistance and is able to use virtual technology to treat many non-emergency conditions.

Teladoc may be contacted as follows: 1 (800) 362-2667, or through the following website www.teladoc.com

ARTICLE V - MEDICAL BENEFITS

Medical Benefits

Subject to the Plan's provisions, limitations and Exclusions, the following are covered medical benefits:

Acquired Brain Injury. Benefits for eligible expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition, and includes the following services: Cognitive Rehabilitation Therapy; Cognitive Communication Therapy; Neurocognitive Therapy and Rehabilitation; Neuro-behavioral; Neurophysiological, Neuropsychological and Psychophysiological Testing and Treatment; Neurofeedback Therapy and Remediation; Post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services; and reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that an acquired brain injury does not result in hospitalization or acute care treatment does not affect the right of the Participant to receive the preceding treatments or services commensurate with their condition. Post-acute care treatment or services may be obtained in any facility where such services may legally be provided, including acute or post-acute rehabilitation hospitals and assisted living facilities regulated under the Health and Safety Code.

Treatment for an Acquired Brain Injury may be provided at a hospital, an acute or post-acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided. (Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury, and therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.)

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration.

Allergy Services. Charges related to the treatment of allergies, including injections, testing and serum.

Ambulance. Transportation by professional ambulance, including approved available air and train transportation (excluding chartered air flights), to a local Hospital or transfer to the nearest facility having the capability to treat the condition.

Ambulatory Surgical Center. Services of an Ambulatory Surgical Center for Medically Necessary care.

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

Aquatic Therapy. Professional charges of a physical therapist or other recognized licensed Provider for physical therapy modalities administered in a pool, which require direct one-on-one patient contact when a medical diagnosis exists, and services are Medically Necessary.

Autism. Generally recognized services prescribed in relation to Autism Spectrum Disorder by the Participant's Physician or behavioral health practitioner are covered.

Individuals providing treatment prescribed under that plan must be a Health Care Practitioner: who is licensed, certified, or registered by an appropriate agency of the state of Texas; whose professional credential is recognized and accepted by an appropriate agency of the United States; or who is certified as a Provider under the TRICARE military health system; or an individual acting under the supervision of a Health Care Practitioner described above.

For purposes of this section, generally recognized services may include services such as:

- evaluation and assessment services;
- screening at 18 and 24 months;
- applied behavior analysis;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy; or
- medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

Benefits for Autism Spectrum Disorder as described herein will be subject to any applicable maximum amounts as indicated in the Schedule of Benefits, based on the services received.

Biofeedback. Medically Necessary services when performed by a covered Provider in conjunction with treatment of a mental health or other medical condition.

Birthing Center. Services of a birthing center for Medically Necessary care provided within the scope of its license. *(Does not include coverage for expenses incurred for the home delivery of a newborn.)*

Blood and Plasma. Blood transfusions, plasma and blood derivatives and charges for whole blood not donated or replaced by a blood bank.

Bone Mass Measurement. Benefits for detection and prevention of osteoporosis as follows:

Coverage is available for medically accepted bone mass measurement for the detection of low bone mass and to determine a Participant's risk of osteoporosis and fractures associated with osteoporosis for the following individuals:

- A postmenopausal woman not receiving estrogen replacement therapy;
- An individual with vertebral abnormalities, primary hyperparathyroidism, or a history of bone fractures; or
- An individual who is: receiving long-term glucocorticoid therapy or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Botox. Services and supplies related to the administration of Botox as administered in a Physician's office, provided services are Medically Necessary to treat a covered Diagnosis. In addition to the coverage that is provided under the Medical Plan, benefits are available for Botox as allowable through the Plan's prescription drug program. In such an instance, benefits may be obtained from the Medical Plan, or prescription drug program, but not both. For Botox that is obtained through the Plan's prescription drug program, any Physician's fee associated with dispensing such medication will be eligible for payment under the Medical Plan.

Breast Pumps / Lactation Support. Comprehensive lactation support and counseling, by a trained Provider during pregnancy and/or in the postpartum period, and costs for buying or renting breastfeeding equipment in conjunction with each birth will be covered under the preventive care benefit. This covers either a manual or electric grade breast pump, not to exceed one per pregnancy. This provision does not provide coverage for other breast-feeding supplies such as maternity bras, nursing pads, additional bottles, and other supplies. To be covered, lactation support and counseling must be provided by a trained Provider. Covered lactation services include counseling services and lactation classes.

Note: Certain Covered Services are provided under the Preventive Care benefit as described in this Medical Benefit section.

Cardiac Rehabilitation. Charges for cardiac rehabilitation as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion, or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan;

Cataracts. Cataract surgery and one set of lenses (contacts or frame-type).

Chemotherapy. Charges for chemotherapy.

Chiropractic Care. Spinal adjustment and manipulation, x-rays for manipulation and adjustment and other modalities performed by a Physician or other licensed practitioner. Benefits will be limited to the maximum amount indicated in the Schedule of Benefits.

Cochlear Implantable Hearing Devices. Benefits will be available for Participants up to age 19 for services and supplies related to implantable hearing devices such as, but not limited to, Cochlear or Soundtec. Benefits will be limited to one external device per hearing impaired ear, or replacement of any one component of said device, every three years as medically necessary or audio logically necessary. Coverage for external hardware (charging ports, ear hooks, remote control) will also be covered.

Contact Lenses. Initial contact lenses or glasses as required following cataract surgery.

Contraceptives. Expenses related to insertion and removal of contraceptive implants, injections, diaphragms, and intra-uterine devices (IUD's) and other contraceptive devices administered in a Physician's office. In addition to the coverage that is provided under the Medical Plan, benefits are available for other forms of contraception as allowable through the Plan's prescription drug program. In such an instance, benefits may be obtained from the Medical Plan, or prescription drug program, but not both. For any contraceptive that is obtained through the Plan's prescription drug program, any Physician's fee associated with dispensing such contraception will be eligible for payment under the Medical Plan.

Note: Certain Covered Services are provided under the Preventive Care benefit as described in this Medical Benefit section.

Cosmetic, Reconstructive or Plastic Surgery. The following eligible expenses described below for medically appropriate Cosmetic, reconstructive or plastic surgery will be paid the same as for treatment of any other sickness as shown on the Summary of Benefits:

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant; or
- Treatment provided for reconstructive surgery following cancer surgery; or
- Surgery performed for the treatment or correction of a congenital defect; or
- Reconstructive surgery performed due to craniofacial abnormalities to improve the function of or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Dental Services. Benefits for eligible expenses incurred by a Participant will be provided on the same basis as for treatment of any other sickness as shown in the Schedule of Benefits only for the following:

- Covered oral surgery;
- Services provided which are necessary for treatment or correction of a congenital defect; or
- The correction of damage caused solely by external, violent Accidental Injury to healthy, un-restored natural teeth and supporting tissues. An injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.

Developmental Delay. Services and supplies related to occupational therapy, physical therapy, speech therapy or other medical charges in association with treatment for developmental delays. The Plan allows coverage for occupational, physical, or speech therapy for developmental delay due to Accident or Illness such as Bell's palsy, CVA (stroke), apraxia, cleft palate/lip, recurrent /chronic otitis media, vocal cord nodules, Down's syndrome, and cerebral palsy. Benefits for specific services will be subject to any applicable maximums as indicated in the Schedule of Benefits.

Diabetes Self-Management Training. Medical-surgical expenses provided for the nutritional, educational and psychosocial treatment of the Qualified Participant. Such diabetic self-management training for which a Physician or other Provider has written an order to the Participant or caretaker of the Participant is limited to the following when rendered by or under the direction of a Physician.

Initial and follow-up instructions concerning:

i. The physical cause and process of diabetes;
ii. Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;
iii. Prevention and treatment of special health problems for the diabetic patient;
iv. Adjustment to lifestyle modifications; and
v. Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instructions for the patient.

Diabetes self-management training for Qualified Participants will include understanding the care and management of diabetes, including nutritional counseling and proper use of diabetes equipment and diabetes supplies.

A Qualified Participant means an individual eligible for coverage under this Plan who has been diagnosed with (a) insulin dependent or non-insulin dependent diabetes, (b) elevated blood glucose levels induced by pregnancy, or (c) another medical condition associated with elevated blood glucose levels.

Note Benefits for insulin and diabetic supplies (other than insulin pumps) will be available through the pharmaceutical program chosen by the Employer.

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

Dialysis. Charges for dialysis therapy and treatment.

Dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.

Durable Medical Equipment. Charges for rental, up to the purchase price, of Durable Medical Equipment (including insulin pumps). At its option, and with its advance written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan will also cover the cost of repairs if not required due to misuse, or the cost of replacement if the equipment is no longer functioning, is outside the warranty period and the defect is unable to be repaired.

The Plan does not pay for:

a. Any purchases without its advance written approval;
b. The rental or purchase of items which do not fully meet the definition of "Durable Medical Equipment;"
c. Batteries, and
d. Shipping, or sales tax.

Early Detection of Cardiovascular Disease. Benefits are available for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when performed by a laboratory that is certified by a recognized national organization:

a. Computed tomography (CT) scanning measuring coronary artery calcifications; or
b. Ultrasonography measuring carotid intima-media thickness and plaque.

Tests are available to each covered individual who is older than 45 years of age and younger than 76 years of age. The individual must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

Emergency Room Services and Supplies. Benefits will be payable as specified in the Schedule of Benefits for the following:

- **True Medical Emergency**

Immediate care required for a life-threatening Emergency or Accidental bodily Injury which untreated could result in death or serious bodily impairment.

- **Non-Emergency Use**

Care received for Illness or Injury which does not qualify as a true Emergency Medical Condition.

Note: If the Participant is admitted as inpatient within 24 hours following emergency room visit, the emergency room copayment will be waived.

Foot Disorders. Benefits will be limited to the following:

- Treatment of any condition resulting from weak, strained, flat instable or unbalanced feet, when surgery is performed.
- Treatment of corns, calluses, and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
- Physician office visit for the diagnosis of bunions.
- Treatment of bunions when open cutting operations or arthroscopy is performed.
- Benefits will also be provided for foot care when rendered in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency. (Routine foot care is excluded except as specified).
- Podiatric appliances, including up to two pairs of therapeutic footwear per Plan Year, for the prevention of complications associated with diabetes.

Glaucoma. Treatment of glaucoma.

Hearing Aids. Hearing exam (including audiometric exams), hearing aid evaluation, and hearing aids prescribed, fitted, and dispensed by a Physician or licensed audiologist. Benefits for hearing aids will be limited to the maximum amount indicated in the Schedule of Benefits.

Hinge Health – Musculoskeletal Clinic

Overview

Through the Hinge Health Digital Musculoskeletal (MSK) Clinic, Participants have access to personalized MSK care programs depending on their specific MSK needs. Participants will register online through the Hinge Health website or app, complete a clinically validated screener to determine which program best fits their MSK needs. The programs include:

(a) Prevention - Program designed to increase education with regards to key strengthening and stretching activities around healthy habits. The Prevention program is software based and offered through the Hinge Health app.

(b) Chronic - Program designed to address long term back and joint pain which includes personalized app-guided exercise therapy sessions, 1:1 access to a personalized health coach, personalized education content, and behavioral health support. Participants in the chronic program may also be offered access to virtual sessions with a licensed Physical Therapist and/or the non-invasive ENSO High Frequency Impulse Therapy™ pain management device and service, as appropriate, for symptomatic relief.

(c) Acute - Program designed to address recent injuries which includes live virtual sessions with a dedicated licensed Physical Therapist along with software guided rehabilitation and education.

(d) Surgery - Program designed to address pre/post-surgery rehab for the most common MSK Surgeries which includes personalized app-guided exercise therapy sessions, 1:1 access to a personalized health coach and physical therapist, personalized education content, and behavioral health support.

(e) Expert Medical Opinion - Service offering second opinions for elective MSK procedures.

For applicable programs a participant may obtain up to six virtual physical therapy sessions per episode prior to in-person healthcare provider or physical therapy care (additionally, other state laws may limit access without a physician's referral).

Eligibility

To be eligible for the Hinge Health programs, a Participant must meet each of the following requirements: (i) be enrolled in the Plan, (ii) be age 18 or older, (iii) be located in the United States, and (iv) be approved through the clinical suitability (evaluation performed by Hinge Health prior to enrollment).

Cost

For eligible Participants, Hinge Health is offered at no cost.

Hinge Health Contact Information To get started with Hinge Health, visit:

https://www.hingehealth.com/for/texasschoolshealthbenefits1 to enroll.

For any questions regarding Hinge Health, help@hingehealth.com or call (855) 902-2777.

Home Health Care. Charges for Home Health Care services and supplies are covered only for care and treatment of an Illness or Injury when Hospital or Skilled Nursing Facility confinement would otherwise be required. The Diagnosis, care, and treatment must be certified by the attending Physician and be contained in a home health care plan. Benefits will be payable up to the maximum amount indicated in the Schedule of Benefits for the following charges by a Home Health Care Agency:

a. Registered Nurses or Licensed Practical Nurses;
b. Certified home health aides under the direct supervision of a Registered Nurse;
c. Registered therapist performing physical, occupational or speech therapy;
d. Physician calls in the office, home, clinic, or outpatient department;
e. Services, Drugs, and medical supplies which are Medically Necessary for the treatment of the Participant that would have been provided in the Hospital, but not including Custodial Care; and

f. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.
g. Benefits do not include coverage for transportation services, Custodial Care, or respite care.

Note: Services for Home Infusion Therapy will not apply to reduce the Home Health Care maximum allowable number of visits.

Hospice Care. Charges relating to Hospice Care, provided the Participant has a life expectancy of 6 months or less. Covered Hospice expenses are limited to the maximum amount indicated in the Schedule of Benefits as applicable and include the following:

a. Room and Board for confinement in a Hospice;
b. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of
Durable Medical Equipment which is used solely for treating an Injury or Illness;
c. Medical supplies, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;
d. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.);
e. Home health aide services;
f. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide;
g. Medical social services by licensed or trained social workers, Psychologists, or counselors;
h. Nutrition services provided by a licensed dietitian;
i. Respite care; and
j. Bereavement counseling, which is a supportive service provided by the Hospice team to Participants in the deceased's family after the death of the terminally ill person, to assist the Participants in adjusting to the death. Benefits will be payable for the family if the following requirements are met:

    i. On the date immediately before his or her death, the terminally ill person was in a Hospice;
    Care Program and a Participant under the Plan; and
    ii. Charges for such services are Incurred by the Participants within 6 months of the terminally ill person's death.

Note: The Hospice Care program must be renewed in writing by the attending Physician every 30 days. Hospice Care ceases if the terminal Illness enters remission.

Hospital. Charges made by a Hospital for:

a.) Inpatient Treatment

i. Daily Room and Board charges;
ii. Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges;
iii. General nursing services; and
iv. Medically Necessary services and supplies furnished by the Hospital, other than Room and Board.

b.) Outpatient Treatment

i. Emergency room;
ii. Treatment for chronic conditions;
iii. Physical therapy treatments;
iv. Hemodialysis; and
v. X ray, laboratory, and linear therapy.

Infertility Testing and Treatment. Benefits will be limited to diagnostic procedures and related expenses (including X-ray and laboratory examinations) performed solely to determine the cause of infertility.

Infusion Therapy. Benefits will be available for infusion therapy for the administration of fluids, nutrition, or medication (including all additives and chemotherapy) by intravenous (IV) or gastrointestinal (enteral) infusion or by intravenous injection. Infusion therapy includes:

- Drug and IV solutions,
- Pharmacy compounding and dispensing services,
- All equipment and ancillary supplies necessitated by the defined therapy,
- Delivery services,
- Patient and family education,
- Nursing services,
- Some infusion therapy drugs may be considered under the Specialty Drug benefit. Please refer to prescription drug provisions for additional information regarding these benefits.

Note: Over-the-counter products which do not require a prescription, including standard nutritional formulations used for enteral nutrition therapy are not covered.

Injectable Medication. Medications and supplies related to the administration of injectable prescription medications. In addition to the coverage that is provided under the Medical Plan, benefits are available for certain medications as provided through the Plan's prescription drug program. In such an instance, benefits may be obtained from the Medical Plan, or prescription drug program, but not both. For any drug that is obtained through the Plan's prescription drug program, any Physician's fee associated with dispensing such medication will be eligible for payment under the Medical Plan.

Note: Certain medications may be subject to the Specialty Drug benefit provisions. Please refer to prescription drug provisions for additional information regarding these benefits.

Massage Therapy. Professional charges for massage therapy modalities administered by a Physical or Occupational Therapist when a medical diagnosis exists, and services are Medically Necessary.

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

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

a. Reconstruction of the breast on which the Mastectomy has been performed;
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
c. Prostheses and physical complications from all stages of Mastectomy, including lymphedemas; in a manner determined in consultation with the attending Physician and the patient.

This coverage will be subject to the same annual Copayment and coinsurance provisions that currently apply to Mastectomy coverage.

Medical Supplies. Dressings, casts, splints, trusses, braces, and other Medically Necessary medical supplies with the exception of, dental braces or corrective shoes.

Mental Health and Substance Abuse Benefits. Benefits are available for Inpatient or Outpatient care for mental health and Substance Abuse conditions, including individual and group psychotherapy, psychiatric tests, and expenses related to the Diagnosis when rendered by a covered Provider. Benefits are available for Residential Treatment Facility, Partial Hospitalization, and Intensive Outpatient Services.

Note: Benefits for the medical management of acute, life-threatening intoxication (toxicity) in a Hospital will be available on the same basis as any other Illness.

Morbid Obesity. Treatment of Morbid Obesity, which means a Body Mass Index (BMI) of greater than or equal to 40 kg/meter^2 or a BMI greater than or equal to 35 kg/meters$^{2.}$ Benefits under this Plan will be limited to expenses incurred for treatment by a covered Provider, and will include, but not be limited to, the following:

- office visits;
- behavior modification;
- required x-ray and laboratory examinations; and
- bariatric surgical interventions*.

*Note: Bariatric surgery for the treatment of Morbid Obesity will be limited to the maximum indicated in the Schedule of Benefits and will be eligible for coverage under the Plan when at least two of the following co-morbid conditions have not responded to a maximum medical management and which are generally expected to be reversed, or improved, by the bariatric treatment:

- hypertension;
- dyslipidemia;
- type 2 diabetes;
- coronary heart disease; or
- sleep apnea.

Newborn Care. Medically Necessary expenses incurred by a newborn infant during his initial Hospital Confinement. Benefits include services and supplies furnished by the Hospital and Physician. Inpatient Physician care for a healthy, full-term, newborn includes, but is not limited to, examinations and the circumcision of male infants.

Covered expenses for a newborn child incurred for Hospital and Physician services will be made on the same basis as any other Illness. Benefits will be payable as expenses of the Child.

Covered expenses for newborn children will be payable for the first 31 days commencing on the date of the Child's birth. For coverage to continue beyond that time, the Employee must properly enroll his Dependent for Dependent benefits within 31 days as specified in the Eligibility section of this Plan Document.

Nursing Services. Services of a Registered Nurse or Licensed Practical Nurse.

Nutritional Counseling. Medically Necessary nutritional counseling for chronic conditions in which dietary adjustment has a therapeutic role, when it is prescribed by a Physician and furnished by a recognized Provider (e.g., licensed nutritionist, registered dietician, or other qualified licensed health professionals such as nurses who are trained in nutrition). Medical nutrition therapy involves the assessment of the person's overall nutritional status followed by the assignment of individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic Illness or condition.

Nutritional Supplements or Infant Formula. Services and supplies, including but not limited to, feeding tubes, pumps, bags, nutritional supplements, or formula, if administered through a tube as the sole source of nutrition for an infant, or enteral and parenteral support for other Participants when used as the sole source of nutrition for that Participant.

Occupational Therapy. Rehabilitation treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing outpatient facility.

Oral Surgery. Oral Surgery means maxillofacial surgical procedures limited to:

a. Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exam;
b. Surgical procedures to correct Accidental Injuries of the jaws, cheeks, lips, tongue, and floor of mouth;
c. Reduction of fractures and dislocations of jaw;
d. External incision and drainage of cellulitis;
e. Incision of accessory sinuses, salivary glands, or ducts;
f. Excision of exostosis of jaws and hard palate;
g. Medically appropriate Hospital services (also includes, but is not limited to anesthesia, x-ray and lab services render in conjunction with Hospital services).

Orthotic devices. Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces, casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint, and custom-molded foot orthotics but excluding orthopedic shoes (unless attached to a brace), and other supportive devices for the feet, except as otherwise specified.

Pathology Services. Charges for pathology services.

Physical Therapy. Rehabilitation treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free standing duly licensed Outpatient therapy facility.

Physician Services. Services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care and surgical opinion consultations.

Pre-Admission Testing
If a Participant is to be admitted to a Hospital for non-Emergency Surgery or treatment, laboratory tests and x ray examinations performed on an Outpatient basis prior to such Hospital admission.

Pregnancy Expenses. Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending Provider" include a plan, Hospital, managed care organization, or other issuer.

Note: Benefits are available for expenses incurred by an Employee, Spouse or Dependent daughter. Certain Covered Services may be provided under the Preventive Care benefit as described in this Medical Benefits section.

Preventive Care. Charges for Preventive Care services. This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer In-Network coverage for certain preventive services without cost-sharing.

Benefits mandated through the Affordable Care Act (ACA) legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources Services Administration (HRSA), and the Federal Centers for Disease Control (CDC) but will also include coverage for other services identified and billed as routine or part of a routine physical exam.

Benefits include gender-specific Preventive Care services, regardless of the sex the Participant was assigned at birth, his or her gender identity, or his or her recorded gender.

See the following websites for more details:

https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/uspstf/search_results?searchterm=A+%26+B+
https://www.hrsa.gov/womens-guidelines-2016

Important Note: The Preventive Care services identified through the above links are recommended services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered.

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

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

a. Benefits will include, but are not limited to the following services:

- Routine physical exams;
- Routine mammography screenings for women ages 35 and older;
- Routine pelvic exam and pap tests;
- Routine fecal blood culture;
- Routine PSA test and prostate exam;
- Routine colonoscopy, sigmoidoscopy, and similar routine procedures;
- Immunizations;
- Routine hearing exams *(all ages),* and
- Routine vision screening exams *(does not include refractive-error exam).*

b. A description of Preventive and Wellness Services can be found at:
https://www.healthcare.gov/coverage/preventive-care-benefits/;
or at the websites listed above.

c. In addition to coverage that is provided for services mandated under the Affordable Care Act, benefits will also be provided for other expenses incurred in relation to other routine care. Services must be identified and billed as routine or part of a routine physical exam, and will include, but are not limited to, wellness or office exams billed by the Physician with a covered preventive diagnosis, immunizations, screenings, and other services.

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

1. Well-woman visits;
2. Gestational diabetes screening;
3. Human papillomavirus (HPV) Deoxyribonucleic Acid (DNA) testing;
4. Sexually transmitted infection counseling;

5. Human Immunodeficiency Virus (HIV) screening and counseling;
6. Food and Drug Administration (FDA)-approved contraception methods and contraceptive counseling;
7. Breastfeeding support, supplies and counseling; and
8. Domestic violence screening and counseling

A description of Women's Preventive Services can be found at:
https://www.hrsa.gov/womens-guidelines-2016 or at the websites listed above.

Prosthetics. Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, and charges for repair if not required due to misuse.

Radiation Therapy. Charges for radiation therapy and treatment.

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

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

a. The clinical trial is approved by:

   i. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
   ii. The National Institute of Health;
   iii. The U.S. Food and Drug Administration;
   iv. The U.S. Department of Defense;
   v. The U.S. Department of Veterans Affairs; or
   vi. An Institutional review board of an Institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and

b. The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Coverage will not be provided for:

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

Second Surgical Opinions. Charges for second surgical opinions, provided the surgical opinions are obtained from Providers who are not in the same group practice or clinic. In the event the two opinions are conflicting, benefits will be payable at the same benefit level for a third surgical opinion.

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

Sleep Disorders. Medically Necessary services and supplies rendered by covered Providers for the treatment for sleep disorders, including sleep studies, if medically appropriate.

Smoking Cessation. Services and supplies related to treatment for the cessation of smoking when rendered by a covered Provider. Medications for smoking cessation will be available through the prescription drug program portion of the Plan.

Note: Certain Covered Services are provided under the Preventive Care benefit as described in this Medical Benefit section.

Speech Therapy. Speech therapy, for Rehabilitation purposes, by a Physician or qualified speech therapist, when needed due to an Illness or Injury (other than a functional Nervous Disorder) or due to Surgery performed as the result of an Illness or Injury, excluding speech therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders.

Sterilization. All Food and Drug Administration (FDA) approved charges related to sterilization procedures.

Note: Certain covered services may be provided under the Preventive Care benefit as described in this Medical Benefit Descriptions section.

Surgery. Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:

a. Multiple procedures adding significant time or complexity will be allowed at:

    i. 100% of the full Maximum Allowable Charge for the first or major procedure;
    ii. 50% of the Maximum Allowable Charge for the secondary and subsequent procedures;
    iii. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at 100% of the Maximum Allowable Charge for the major procedure, and 50% of the Maximum Allowable Charge for the secondary or lesser procedure;

b. The Maximum Allowable Charge for services rendered by an assistant surgeon will be limited to 20% of the Maximum Allowable Charge identified for the surgeon's service; and

c. No benefit will be payable for incidental procedures, such as appendectomy during an abdominal Surgery, performed during a single operative session.

Surgical Treatment of Jaw. Surgical treatment of Illnesses, Injuries, fractures, and dislocations of the jaw by a Physician or Dentist.

Note: Benefits do not include coverage for treatment of Temporomandibular Joint Disorder or any associated condition.

Telehealth Services and Telemedicine Medical Services. Benefits will include coverage for telephone and internet services which transpire between patient and Physician. Services may be provided via consultation with a licensed medical professional through interactive audio via telephone or interactive audio-video via online portal or mobile application.

Note: In addition to the above coverage, benefits will also include coverage for telehealth services as provided by Teladoc, a medical service that uses telephone and videoconferencing technology to provide remote medical care via mobile devices, the internet, video, and phone.

Transplant Expenses.
Once it has been determined that a Participant may require an organ transplant, the Participant, or attending Physician should call the precertification department to discuss coordination of the transplant care. In some cases, Aetna will coordinate transplant services. In addition, the Participant must follow any precertification requirements. ("Organ" means solid organ, stem cell, bone marrow, and tissue.)

Benefits may vary if an Institute of Excellence ™ (IOE) facility or non-IOE is used. In addition, some expenses listed below are payable only within the IOE Network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure required by the Participant.

A transplant will be covered as preferred care only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any treatment or service related to transplants, which is provided by a facility not specified as an IOE Network facility even if the facility is considered as a preferred facility for other types of services, will not be covered.

Covered Donor Expenses
Surgical, storage and transportation costs directly related to the procurement of an organ or tissue used in a transplant described herein will be covered, provided the organ recipient is covered under the Plan. If an organ or tissue is sold rather than donated, no benefits will be available for the purchase price of such organ or tissue.

Covered Transplant Expenses
Covered transplant expenses include the following:

- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are the Participant's biological parent, sibling, or child.
- Inpatient and outpatient expenses directly related to a transplant.
- Charges made by a Physician or transplant team.
- Charges made by a Hospital, outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may be excluded: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one Transplant Occurrence.

A Transplant Occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one Transplant Occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant Evaluation/Screening: Includes all transplant-related professional and technical components required for assessment, evaluation, and acceptance into a transplant facility's transplant program.

2. Pre-transplant/Candidacy Screening: Includes HLA typing/compatibility testing of prospective organ donors (related and/or non-related).

3. Transplant Event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement.

4. Follow-up Care: Covered services vary among IOE contracts, most often excludes home health care services; home infusion services; and immunosuppressants.

For the purposes of this section, the following will be considered to be one Transplant Occurrence:

- Heart
- Lung
- Heart/ Lung
- Simultaneous Pancreas Kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone Marrow/Stem Cell transplant
- Multiple organs replaced during one transplant surgery
- Tandem transplants (Stem Cell)
- Sequential transplants
- Re-transplant of same organ type within 180 days of the first transplant
- Any other single organ transplant, unless otherwise excluded under the Plan

The following will be considered to be <u>more than one</u> Transplant Occurrence:

- Autologous Blood/Bone Marrow transplant followed by Allogeneic Blood/Bone Marrow transplant (when not part of a tandem transplant)
- Allogeneic Blood/Bone Marrow transplant followed by an Autologous Blood/Bone Marrow transplant (when not part of a tandem transplant)
- Re-transplant after 180 days of the first transplant
- Pancreas transplant following a kidney transplant
- A transplant necessitated by an additional organ failure during the original transplant surgery/process.
- More than one transplant when not performed as part of a planned tandem or sequential transplant (e.g., a liver transplant with subsequent heart transplant).

Exclusions/Limitations

The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient Transplant Occurrence.
- Services and supplies furnished to a donor when recipient is not a covered person.
- Home infusion therapy after the Transplant Occurrence.
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness.
- Harvesting and/or storage of bone marrow, tissue, or stem cells without the expectation of transplantation within 12 months for an existing illness.
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by 90 Degree Benefits.

Travel & Lodging Expenses

Distance Requirement
The IOE facility must be more than 75miles from the patient's residence.

Optional Travel & Lodging Expenses
If the IOE facility is more than 75 miles from the patient's residence, travel expenses may be reimbursed for travel between the patient's home and the facility for round trip (air, train, or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking, and toll cost are reimbursed. Depending on the situation, some lodging may also be reimbursed. Such expenses should be discussed in advance with 90 Degree Benefits to understand what is or is not covered.

Overall Maximum
Travel & Lodging reimbursement will be covered at 100%, and Deductible requirements will not apply, however the benefit is limited to $10,000 for any one transplant or procedure type, including tandem transplants. This is a combined maximum for the member, companion, donor, and donor companions.

- Adult – 1 companion is permitted.
- Child – 2 parents or guardian is permitted.

Note: In order to obtain benefits, services must be obtained through an Institute of Excellence ™ (IOE) facility approved by and accessed through TSHBP's Care Management Program. Expenses billed for transplant services which are not included in the transplant network will not be covered.

Urgent Care Facilities. A facility that is engaged primarily in providing minor emergency and episodic medical care and that has a board-certified Physician, a licensed registered graduate nurse (R.N.), and a registered x-ray technician in attendance at all times, x-ray / laboratory equipment and a life support system.

Wigs/ Hairpieces. Benefits will be available for wigs, toupees, hairpieces when required due to treatment for cancer or other medically appropriate conditions. Benefits will be subject to the maximum amount indicated in the Schedule of Benefits.

ARTICLE VI - MEDICAL EXCLUSIONS AND LIMITATIONS

The following Exclusions and limitations are in addition to those set forth in the Articles entitled "General Limitations and Exclusions," and "Summary of Benefits."

Abortion. Expenses incurred with the induced termination of a pregnancy will not be covered.

Acupuncture. Charges relating directly or indirectly to acupuncture, including acupuncture provided in lieu of anesthetic.

Alternative / Complimentary Treatment. Benefits will be unavailable for the following:

- Holistic or homeopathic medicine;
- Hypnosis;
- Other alternative medicine that is not accepted medical practice as determined by the Plan.

Blood Pressure Cuffs/Monitors.

Breast Reductions *(unless medically appropriate.)*

Charges for failure to keep a scheduled visit, or charges for completion of a claim form.

Complications. Expenses related to treatment of complications of a non-covered service.

Consultations Online/Telephone. Expenses incurred for telephone or online consultations from Physician to Physician.

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

- necessary due to a non-occupational Accidental Injury; or
- necessary for correction of post-surgical deformity or congenital defects.

Custodial Care. Custodial Care, respite care, domiciliary care or rest cures, or Home Health Care, except as otherwise specified as a covered expense.

Dental Implants.

Drugs Requiring a Written Prescription. (except those specified, those taken or administered in whole or in part during confinement in a licensed facility or those administered in a Physician's office) are not covered by this Plan. They are provided under a separate plan provided by the Employer through Liviniti *(Southern Scripts)*.

Educational or Vocational Testing. Services for educational or vocational testing or training, except as otherwise specified or diabetes training.

Eyeglasses / Contact Lenses. Eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Illness or Injury).

Foot Care. Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails, in the absence of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency, except as otherwise specified.

Genetic Counseling / Genetic Testing. Services and supplies related to genetic counseling or genetic testing, except for those for which coverage is mandated as provided under the Affordable Care Act.

Growth Hormones. Services and supplies related to the administration of growth hormones.

Hormone Pellet Therapy. Services and supplies related to hormone pellet therapy.

Impregnation and Infertility Treatment. The following charges related to Impregnation and Infertility Treatment: artificial insemination, fertility Drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency Drugs such as Viagra™, in-vitro fertilization, surrogate mother, donor eggs, fertility tests, tests and exams done to prepare for conception, and other related services, except as otherwise specified.

Note: If the surrogate is a Participant, then the Preventive Care and/or Pregnancy expenses will be covered in accordance with the Plan provisions.

Marriage Counseling.

New To Market Medications. All new to market medications approved by the FDA, including "Specialty Drugs" are not covered during a twelve (12) month evaluation period by the Plan regardless of the site of dispensing (i.e., either pharmacy or medical management such as clinic, Physician's office, etc.). After the six (6) month evaluation period, a determination will be made by the Plan and the contracted pharmacy benefit manger's Pharmacy and Therapeutics (P&T) Committee whether such prescription drugs are Formulary, non-Formulary, or non-covered.

Note: Claims incurred during the 12-month evaluation period are not covered, nor will they be eligible for retroactive consideration. Claims incurred after the evaluation period is completed will be processed according to the classification of formulary, non-formulary, or not covered. In addition, certain medications may be subject to the Specialty Drug benefit provisions. Please refer to prescription drug provisions for additional information regarding these benefits.

No Physician recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Illness.

Obesity. Care and treatment relating to weight loss or dietary control, including the care and treatment of obesity whether or not it is, in any case a part of the treatment plan for another Sickness. Medically Necessary charges for the treatment of Morbid Obesity will be eligible for coverage, subject to the Plan provisions as indicated.

Note: This exclusion does not apply to any service or supply required by the Patient Protection and Affordable Care Act (PPACA), as amended by the Reconciliation Act and related regulatory guidance, to be included as a Covered Service under the Preventive Care benefit.

Oral Surgery. Oral surgery or dental treatment, except as specifically provided in the Plan.

Organ Transplants. Expenses related to donation of a human organ or tissue, except as specifically provided.

Orthognathic / Prognathic Surgery. Services and supplies related to orthognathic or prognathic surgery, except as otherwise specified.

Orthopedic Shoes. Orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, and other supportive devices for the feet, except as otherwise specified.

Orthoptics. Orthoptics, vision training, or vision therapy.

Panniculectomy / Abdominoplasty.

Personal Convenience Items. Equipment that does not meet the definition of Durable Medical Equipment, or are primarily used for environmental control or enhancement, including, but not limited to, air conditioners, air purifiers, hypoallergenic mattresses and pillows, motorized scooters, ramps, personal comfort items or hygiene items, communication devices, humidifiers, and exercise equipment, whether or not recommended by a Physician.

Radial Keratotomy. Radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses.

Reversal of a Sterilization Procedure. Expenses related to the reversal of a sterilization procedure.

Sales Tax, Shipping and Handling Charges.

Sex Assignment / Reassignment. Related to a sex assignment or sex reassignment operation.

Sexual Dysfunction. Services related to male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause, including prescriptions drugs, sex counseling, penile prosthetic implants, and all other procedures and equipment developed for or used in the treatment of impotency.

Take-Home Medication.

Temporomandibular Joint Disorder. Services or supplies (Diagnostic, surgical, dental restorations, orthodontics, physical therapy, oral appliances, oral splints, oral orthotics, devices, prosthetics, or any other service or supply) provided for the treatment of the temporomandibular joint (including the jaw and craniomandibular joint) and all adjacent or related muscles.

Travel. Travel, whether or not recommended by a Physician, except as specifically provided herein.

Vitamins. Vitamins, except as specified under Preventive Care.

Wilderness Treatment Programs. Wilderness treatment programs (whether or not the program is part of a licensed Residential Treatment Facility or otherwise licensed institution).

ARTICLE VII - PRESCRIPTION DRUG BENEFITS

Participating pharmacies ("Participating Pharmacies") have contracted with the Plan to charge Participants reduced fees for covered Drugs. Liviniti *(Southern Scripts)* is the administrator of the prescription Drug plan. Participants will be issued an identification card to use at the pharmacy at time of purchase. Participants will be held fully responsible for the consequences of any pharmacy identification card after termination of coverage.

The Mail Order Option is available for maintenance medications (those that are taken for long periods of time, such as Drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of the volume buying, Southern Scripts, the mail order pharmacy, is able to offer Participants significant savings on their prescriptions.

Benefits for Prescription Drugs will be subject to the Prescription Drug Deductible as indicated in the Prescription Drug Schedule of Benefits. Once the Deductible has been satisfied, benefits for Prescription Drugs will be available as indicated in the Schedule.

Copayment or Coinsurance amounts are applied to each charge and are shown on the Schedule of Benefits. Prescription Drug Deductible, Copayment and Coinsurance amounts will apply towards fulfilling the Medical Plan's Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum is met, no further Deductible, Copayment, or Coinsurance amounts will be applied for the remainder of that Plan Year.

Covered Expenses
Coverage includes, but is not limited to the following:

Acne Control;

Allergy Medications;

Bee Sting Kits. Charges for EPI PEN and Ana Kit;

Botox (non-cosmetic use only, subject to authorization);

Compounded Prescriptions. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity;

Contraceptives. All Food and Drug Administration (FDA) approved contraceptives Drugs, in accordance with the Health Resources and Services Administration (HRSA) guidelines;

*Note**:** All other contraceptive methods are covered under the Preventive Care benefit in the medical plan*;

Drug Efficacy Study Implementation (DESI) Drugs. Charges for DESI Drugs;

Diabetes. Insulins, insulin syringes and needles, and other diabetic supplies, when prescribed by a Physician;

Note: Additional benefits are available for Participants who enroll in, and comply with, the Diabetes Care Program as contracted by the Plan Sponsor.

Imitrex Injection. Charges for Imitrex injections (migraine auto-injector);

Immunizations /Vaccines / Toxoid;

Legend Drugs (except as otherwise excluded);

Required by Law. All Drugs prescribed by a Physician that require a prescription either by Federal or State law, except injectables (other than insulin) and the Drugs excluded below;

Self-Injectables. A charge for self-injectables (may require prior authorization);

Smoking Deterrents. A charge for Drugs or aids for smoking cessation, including, but not limited to, nicotine gum and smoking cessation patches to the extent required by the Affordable Care Act (ACA);
Steroids. Steroids, with Medical Necessity;

Non-Insulin Syringes/Needles. Charges for non-insulin syringes and needles with a prescription; and

Vitamins. Vitamins, with a prescription, or as required by the Affordable Care Act.

Limitations
The benefits set forth in this Article will be limited to:

1. **Dosages.**
    a. With respect to the Pharmacy Option, any one prescription is limited to a 30-day supply; and
    b. With respect to the Mail Order Option, any one prescription is limited to a 90-day supply.

2. **Refills.**
    a. Refills only up to the number of times specified by a Physician; and
    b. Refills up to one year from the date of order by a Physician.

ARTICLE VIII - PRESCRIPTION DRUG EXCLUSIONS

The following Exclusions and limitations are in addition to those set forth in the Articles entitled "General Limitations and Exclusions," and "Schedule of Benefits:"

Non-Covered Expenses
Coverage excludes, but is not limited to the following:

Administration. Any charge for the administration of a covered Drug;

Allergy Sera. Charges for allergy sera;

Blood and Blood Plasma. Charges for blood and blood plasma;

Consumed Where Dispensed. Any Drug or medicine that is consumed or administered at the place where it is dispensed;

Devices. Devices of any type, even though such devices may require a prescription, including, but not limited to, therapeutic devices, artificial appliances, braces, support garments or any similar device;

Excluded Items. Any charge excluded under the Articles entitled "General Limitations and Exclusions," or "Summary of Benefits;"

Experimental Drugs. Experimental Drugs and medicines, even though a charge is made to the Participant;

FDA. Any drug and/or drug combination not approved by the Food and Drug Administration;

Fertility Agents. Charges for fertility agents;

Growth Hormones;

Impotency. A charge for impotency medication, including Viagra;

Institutional Medication. A Drug or medicine that is to be taken by a Participant, in whole or in part, while confined in an Institution, including any Institution that has a facility for dispensing Drugs and medicines on its premises;

Investigational Use Drugs. A Drug or medicine labeled "Caution – limited by Federal law to Investigational use;"

Medical Devices and Supplies. Charges for legend and over the counter medical devices and supplies;

No Charge. A charge for Drugs which may be properly received without charge under local, State or Federal programs;

Non-Prescription Drug or Medicine. A Drug or medicine that can legally be bought without a prescription, except for injectable insulin or as otherwise required under the Affordable Care Act;

Occupational. Prescriptions necessitated due to an occupational activity or event occurring as a result of an activity for wage or profit which an eligible person is entitled to receive without charge under any workers' compensation or similar law;

Orphan Drugs. A term for a drug that treats a rare disease, defined by the Food and Drug Administration (FDA) as one that affects fewer than 200,000 Americans;

Rogaine. Charges for Rogaine (topical minoxidil);

Vitamins.

(Exclusion does not apply to those vitamins for which coverage is required under the Affordable Care Act).

ARTICLE IX - COST CONTAINMENT

Cost Containment

Failure to comply with Utilization Management will result in a higher cost to Participants. "Utilization Management" includes Hospital pre-admission certification, continued stay review, length of stay determination and discharge planning. These programs are designed to ensure that Medically Necessary, high quality patient care is provided and enables maximum benefits under the Plan.

Some Covered Services are subject to Pre-Certification requirements, as indicated in below. Please contact the Utilization Management Provider regarding specific services, surgeries or other procedures that may require Pre-Certification and details on how to obtain Pre-Certification.

All Inpatient admission and/or procedures must be pre-certified

- Inpatient Hospitalization;
- Residential Treatment Facility stays;
- Long-term acute care;
- Skilled Nursing Facility;
- Hospice – when inpatient;

Outpatient Procedures

- Applied Behavioral Analysis Therapy (more than 12 visits);
- AICD and Biventricular device insertions;
- Arthroplasty;
- AV Fistula or graft access for dialysis;
- Back pain related injections: Epidural steroid injections, facet joint injections, medial branch block, trigger point injections, sacroiliac joint injection, percutaneous rhizotomy;
- Bariatric Surgery;
- Blepharoplasty;
- Bone Growth Stimulator;
- BRCA Genetic Testing Program;
- Breast Reconstruction;
- Breast Reduction;
- Cardiac Catheterizations;
- Cartilage Implants;
- Chemical Dependency/Behavioral Health PHP and IOP (partial hospitalization program and intensive outpatient program);
- Chemotherapy/Radiation Oncology;
- Clinical Trials;
- Cochlear Implants;
- Cosmetic and Reconstructive;
- Dialysis;
- Durable Medical Equipment (DME) – greater than $2,500 billed;
- Experimental, Investigational and Potentially Unproven Services;
- Following back or neck procedures: IDET (intradiscal Electrothermal Annuloplasty), Percutaneous Radiofrequency Neurotomy, Artificial Intervertebral Disk Implantation, Automated Percutaneous Lumbar Discectomy (APLD);
- Hernia Repair – Abdominal including ventral, hiatal and umbilical;
- Home Care – Nutritional, Skilled Nursing, Private Duty Nursing, Home physical/occupational, respiratory and/or speech therapy (Outpatient only);
- Hospice Services – Outpatient;
- Hyperbaric Oxygen Therapy;
- Hysterectomies;
- Infusions/high cost injectables (including Botox);

- Intensity-Modulated Radiation Therapy (IMRT);
- Joint Replacement (Arthrotomy);
- MR-guided Focused Ultrasound (MRgFUS);
- Nasal surgeries;
- Nuclear Medicine (Diagnostic / therapeutic);
- Observation stays (Greater than 23-hour observation stay);
- Orthognathic Surgery *(Plan covers treatment of Illnesses, Injuries, fractures, and dislocations of the jaw by a Physician or Dentist. TMJ/ associated disorders are not covered);*
- Outpatient Residential Treatment Facility;
- Prosthetic and Orthotic purchase in excess of $2,000 billed;
- Proton beam radiotherapy;
- Rehab program (such as Pulmonary, Physical Therapy, Occupational Therapy, Speech Therapy, Cognitive Therapy, more than 12 visits per therapy);
- Sclerotherapy;
- Shock wave lithotripsy / radiation for plantar fasciitis;
- Sleep Studies;
- Spinal Surgeries when fusions and implants are used;
- UP3/UPPP – Uvulopalatopharyngoplasty;
- Transplant Candidacy Evaluation and Transplant (organ and/or tissue);
- Varicose vein procedures;
- Ventricular Assist Devices;
- Wound Care;

Diagnostic testing

- CT Scan;
- MRA;
- Magnetic resonance spectroscopy (MRS);
- MRI;
- PET Scan;
- SPEC Scan.

Remember that although the Plan will automatically pre-authorize a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours for a cesarean delivery, it is important that the Participant has his/her Physician call to obtain pre-certification if there is a need to have a longer stay.

Notification Only
Notification only is requested for the following services (screen for case management only, not pre-certification):

- Air transport (review for Medical Necessity).

Pre-Certification Procedures
The Inpatient Utilization Management Service is simple and easy for Participants to use. Whenever a Participant is advised that Inpatient Hospital care is needed, it is the Participant's responsibility to call the pre-certification department at its toll-free number, which is located on the Participant's ID card. The review process will continue, as outlined below, until the Participant is discharged from the Hospital.

Urgent Care or Emergency Admissions:
If a Participant needs medical care for a condition which could seriously jeopardize his or her life, he or she should obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

If a Participant must be admitted on an Emergency basis, the Participant, or an individual acting on behalf of the Participant, should follow the Physician's instructions carefully and contact the pre-certification department as follows:

1. For Emergency admissions after business hours on Friday, on a weekend or over a holiday weekend, a call to the pre-certification department must be made within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient; and
2. For Emergency admissions on a weekday, a call to the pre-certification department must be made within 24 hours after the admission date, by or on behalf of the covered patient.

The Plan does not require the Participant to obtain approval of a medical service prior to getting treatment for an urgent care or Emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Non-Emergency Admissions:
For Inpatient Hospital stays that are scheduled in advance, a call to the pre-certification department should be completed as soon as possible before actual services are rendered. Once the pre-certification call is received, it will be routed to an appropriate review specialist who will create an on-line patient file. The review specialist will contact the Participant's attending Physician to obtain information and to discuss the specifics of the admission request. If appropriate, alternative care will be explored with the Physician.

If, after assessing procedure necessity, the need for an Inpatient confinement is confirmed, the review specialist will determine the intensity of management required and will remain in contact with the Physician or Hospital during the confinement.

If, at any time during the review process, Medical Necessity cannot be validated, the review specialist will refer the episode to a board-certified Physician advisor who will immediately contact the attending Physician to negotiate an appropriate treatment plan. At the end of the Hospital confinement, the review specialist is also available to assist with discharge planning and will work closely with the attending Physician and Hospital to ensure that medically appropriate arrangements are made.

The pre-certification department hours of operations are 8 A.M. to 5 P.M. On weekends and evenings, the Participant can call the phone number located on his/her ID card and leave a message.

Pre-Certification Penalty
The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures for pre-certification, he or she will receive the normal Plan benefits. However, if pre-certification is not obtained for any of the services listed above for which pre-certification is required, the provisions listed below will apply.

- Payment of charges will be withheld, and a retroactive review must be requested.
- Upon retroactive review, Medical Necessity must be established. Thereafter, benefits will be determined as follows:
    - If such treatment or service is found to be Medically Necessary, services will be subject to a $300 penalty;
    - If it is determined that the treatment or service was not Medically Necessary, was for a condition not covered by the Plan, or otherwise excluded by Plan provisions, no benefits will be paid;
    - If a Participant is admitted on an Emergency basis, and pre-certification is not obtained within the Emergency Admission timeframes as specified due to extenuating circumstances, if such treatment or service is found to be Medically Necessary, the pre-certification penalty may be waived upon appeal.

Please note, the Participant will be responsible for the payment of any expenses not covered by the Plan.

Furthermore, affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Plan Administrator, will be eligible for payment.

Note: In the event Medicare, or other coverage is primary, pre-certification requirements will be waived.

Case Management

The Plan may, at its sole discretion and when acting on a basis that precludes individual selection, permit alternative benefits that may otherwise not be payable under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's decision to permit the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Participant, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan. Case Management is a voluntary cost management program administered to provide a timely, coordinated referral to alternative care facilities to a Participant who suffers a catastrophic Illness or Injury while covered under this Plan.

The following are examples of diagnoses that might constitute a catastrophic Illness or Injury:

- High Risk Pregnancy
- Neonatal High-Risk Infant
- Cerebral Vascular Accident (CVA or Stroke)
- Multiple Sclerosis
- Amyotrophic Lateral Sclerosis (ALS)
- Cancers/Tumor Malignancy
- Severe Cardio/Pulmonary Disease
- Leukemia
- Major Head Trauma and Brain Injury Secondary to Illness
- Spinal Cord Injury
- Amputation
- Multiple Fractures
- Severe Burns
- AIDS
- Transplant
- Any claim expected to exceed $25,000

When the Case Manager is notified of one of the above diagnoses (or any other diagnosis for which Case Management might be appropriate in the Plan's sole discretion), the Case Manager will contact the Participant to discuss current medical treatment and facilitate future medical care. The Case Manager will also consult with the attending Physician to develop a written plan of treatment outlining all medical services and supplies to be utilized, as well as the most appropriate treatment setting. The treatment plan may be modified intermittently as the Participant's condition changes, with the mutual agreement of the Case Manager, the patient, and the attending Physician.

All services and supplies authorized by the treatment plan will be considered Covered Services, whether or not they are otherwise covered under the Plan. The benefit level for alternative treatment settings may be the same as the Hospital benefit level, in the absence of the Case Management program. For all other services and supplies, the benefit level will be the same as the benefit for Outpatient medical treatment, in the absence of the program.

Any deviation from the treatment plan without the Case Manager's prior approval will negate the treatment plan, and all charges will be subject to the regular provisions of this Plan.

ARTICLE X - ELIGIBILITY FOR COVERAGE

Eligibility for Individual Coverage
Each Employee will become eligible for coverage under this Plan with respect to himself or herself on the date of hire, or on the first day of the month coincident with or following the date of hire, as determined by the participating district, provided the Employee has begun work for his or her Participating Employer. If the Employee is unable to begin work as scheduled, then his or her coverage will become effective on such later date when the Employee begins work. Each Employee who was covered under the Prior Plan, if any, will be eligible on the Effective Date of this Plan. Any Service Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Service Waiting Period of this Plan.

Employee Eligibility
To be eligible for the Texas Schools Health Benefits Program (TSHBP), an individual must be either:

(i) a participating member who is currently employed by a participating district in a position that is eligible for membership in the TRS pension, or
(ii) an individual who is currently employed by a participating district for 10 or more regularly scheduled hours each week in a position that is not eligible for membership;

And

Is not receiving health care coverage as an Employee or retiree under

(i) the Texas State College and University Employees Uniform Insurance Benefits Act (e.g., coverage offered by The University of Texas System or the Texas A & M University System),
(ii) the Texas Employees Uniform Group Insurance Benefits Act (e.g., coverage offered by ERS); or
(iii) TRS-Care.

If a current Employee was an eligible part-time Employee during an enrollment opportunity for the current Plan Year, and later during the current Plan Year the Employee becomes an eligible full-time Employee, the Employee will have a 31-day opportunity, beginning on the first day of becoming an eligible full-time Employee, to enroll himself or herself, as well as his or her eligible Dependents in TSHBP during the current Plan Year. This enrollment opportunity exists even if enrollment in TSHBP during this current plan year was previously declined by the Employee.

A full-time Employee is a participating member of the TRS pension who:

- Is currently employed by a participating district;
- Is employed in a position that IS eligible for membership in the TRS pension; and
- Is not receiving coverage as an employee or retiree from TRS-Care or from a uniform group insurance or health benefits program offered by ERS, the University of Texas, or Texas A & M University.

A part-time employee is an individual who:

- Is currently employed by a participating district;
- Is employed in a position that IS NOT eligible for membership in the TRS pension; and
- Is not receiving coverage as an Employee or retiree from TRS-Care or from a uniform group insurance or health benefits program offered by ERS, the University of Texas, or Texas A & M University.

For purposes of enrollment in TSHBP, individuals who are hired in a substitute position or who have retired under the TRS Pension will be considered part-time Employees, regardless of the numbers of hours they work for the participating district.

Part-time Employees are not entitled to state assistance in the purchase of their TSHBP coverage. The participating district that employs a part-time Employee may, but is not required, to provide assistance in the purchase of TSHBP coverage for the part-time Employee.

Who is Eligible for TSHBP Coverage?

Teachers, administrative personnel, bus drivers, librarians, cafeteria workers, among others, are all eligible for TSHBP coverage, provided no exception applies, if they are employees of the district, not volunteers, and are actively contributing TRS members or are employed by a participating district for 10 or more regularly scheduled hours each week.

Substitutes and return-to-work retirees are always considered part-time regardless of the number of hours worked. However, to be eligible for TSHBP benefits they must have a minimum of 10 or more regularly scheduled hours per week. Independent contractors and volunteers are not employees and are not eligible for TSHBP coverage.

Note: The above eligibility guidelines apply only to TSHBP and do not apply to eligibility for membership in the TRS pension plan. Only employees who are actively contributing TRS members are eligible for funding provided under Chapter 1581, Texas Insurance Code.

Change in Employment Status

In the event a Part-Time or substitute Employee qualifies for benefits by reason of a change in status to a Full-Time Employee as classified above, that Employee will have a 31-day enrollment opportunity beginning on the first day that they become an eligible Employee to enroll themselves, and their Dependents in the Texas Schools Health Benefits Program for coverage during the current Plan Year. Benefits will be effective on the first of the month immediately following or coincident with a 31-day Service Waiting period starting on the date of his/her transition to eligible status.

Reinstatement of Coverage

Applies to the Participating Employers who are not subject to the ACA's employer shared responsibility provisions (section 4980H of the Internal Revenue Code):

> If employment is terminated and the Employee returns to Active Employment within 31 days from the date of termination, the Service Waiting Period will be waived, and coverage will take effect on the first day the Employee returns to Active Employment. Rehired Employees who have continued coverage under COBRA shall not be required to satisfy the Service Waiting Period.

Applies to the Participating Employers who are subject to the ACA's employer shared responsibility provisions (section 4980H of the Internal Revenue Code):

> If employment is terminated and the Employee returns to Active Employment within 26 weeks from the date of termination, the Service Waiting Period will be waived and coverage for the rehired Employee will then be effective on the first of the month following the date of rehire.

Eligibility Dates for Dependent Coverage

Each Employee will become eligible for coverage under this Plan for his or her Dependents on the latest of the following dates:

1. His or her date of eligibility for coverage for himself or herself under the Plan;
2. The date coverage for his or her Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan;
3. The first date upon which he or she acquires a Dependent.

Coverage Guidelines for Family Coverage if both Spouses or a Dependent Child Works for Participating Entities If an Employee and Spouse both work for a participating district, benefits may be elected according to the following provisions:

1. Each Employee may choose Employee-only coverage and select the same or different plan;
2. One member of the Family can select Employee and Spouse coverage, or Family coverage, however the other Spouse will be required to decline further coverage as an Employee under the TSHBP Plan;
3. In the event there are also Dependent Children, they may be covered under the Plan of one parent. In no event will any Dependent Child be covered as a Dependent of more than one Employee who is covered under the Plan.
4. Any reference in this Plan to an Employee's Dependent being covered means that such Employee is covered for Dependent Coverage.
5. If a Child and parent are both eligible as Employees, the Child can be eligible under the parent's plan as a Dependent until the end of the month in which they turn age 26. The Child will be required to decline further coverage as an Employee under the TSHBP Plan.

Effective Dates of Coverage; Conditions
The coverage for which an individual is eligible under this Plan will become effective on the date specified below, subject to the conditions of this section.

1. Enrollment Application (paper or electronic). Coverage for an Employee or his or her Dependents must be requested by the Employee on a form (either paper or electronic as applicable) furnished by the Plan Administrator and will become effective on the date such Employee or Dependents are eligible, provided the Employee has enrolled for such coverage on a form satisfactory to the Plan Administrator within the 31-day period immediately following the date of eligibility.

2. Birth of Dependent Child. A newborn Child of a covered Employee will be considered eligible and will be covered from the moment of birth for a period of 31 days only. For coverage to continue beyond this period, the Employee must submit a written application to the Plan to enroll the Child within the limited 31-day period (i.e., period from the moment of birth). The application must also be accompanied by any required contribution, ongoing, as the case may be. A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an eligible Dependent.

3. Newly Acquired Dependents. If an Employee acquires a Dependent while the Employee is eligible for coverage for Dependents, coverage for the newly acquired Dependent shall be effective on the date the Dependent becomes eligible, provided application is made to the Plan within 31 days of the date of eligibility and any required contributions are made.

4. Requirement for Employee Coverage. No coverage for Dependents of an Employee will become effective unless the Employee is, or simultaneously becomes, eligible for coverage for himself or herself under the Plan.

5. Coverage as Both Employee and Dependent. No person may be simultaneously covered under this Plan as both an Employee and a Dependent.

6. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be considered by the Plan in determining that individual's eligibility under the Plan.

7. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

Special and Open Enrollment
The Plan provides special enrollment periods that allow Employee's to enroll in the Plan, even if they declined enrollment during an initial or subsequent eligibility period.

Loss of Other Coverage
If an Employee declined enrollment for himself or herself or his or her Dependents (including his or her spouse) because of other health coverage, he or she may enroll for coverage for himself or herself and/or his or her Dependents if the other health coverage is lost. The Employee must make written application for special enrollment within 31 days of the date the other health coverage was lost.

The following conditions apply to any eligible Employee and Dependents:
An Employee may enroll during this special enrollment period:

1. If the Employee is eligible for coverage under the terms of this Plan;
2. The Employee is not currently enrolled under the Plan;
3. When enrollment was previously offered, the Employee declined because of coverage under another group health plan or health insurance coverage. The Employee must have provided a written statement that other health coverage was the reason for declining enrollment under this Plan; and
4. If the other coverage was terminated due to loss of eligibility for the coverage (including due to Legal Separation, divorce, death, termination of employment, or reduction in the number of hours), or because Employer contributions for the coverage were terminated.

An Employee who is already enrolled in a benefit package may enroll in another benefit package under the Plan if a Dependent of that Employee has a special enrollment right in the Plan because the Dependent lost eligibility for other coverage. The Employee must make written application for special enrollment in the new benefit package within 31 days of the date the other health coverage was lost.

If an Employee or an eligible Dependent has a special enrollment event under applicable law, Plan changes are also permitted if the Employee is directed by a court order or national medical support notice to provide health coverage for a Dependent Child or if the Employee or a Dependent loses coverage because they no longer live, work, or reside in an HMO service area. The Employee is not eligible for this special enrollment right if:

1. The other coverage was COBRA Continuation Coverage, and the Employee did not exhaust the maximum time available to him or her for that COBRA coverage; or
2. The other coverage was lost due to non-payment of requisite contribution or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Other Plan).

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month after the date of the event.

New Dependent
If an Employee acquires a new Dependent as a result of marriage, legal guardianship, a foster child being placed with the Employee, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself and his or her Dependents during a special enrollment period. The Employee must make written or electronic application (as applicable) for special enrollment no later than 31 days after he or she acquires the new Dependent. The following conditions apply to any eligible Employee and Dependents:

An Employee may enroll himself or herself and/or his or her eligible Dependents during this special enrollment period if:

1. The Employee is eligible for coverage under the terms of this Plan; and
2. The Employee has acquired a new Dependent through marriage, birth, adoption, or placement for adoption or as otherwise specified.

If the conditions for special enrollment are satisfied, coverage for the Employee and his or her Dependent(s) will be effective at 12:01 A.M.:

1. For a marriage, on the first day of the first calendar month after the date of the event;
2. For a legal guardianship, on the date on which such Child is placed in the covered Employee's home pursuant to a court order appointing the covered Employee as legal guardian for the Child;
3. In the case of a foster child being placed with the Employee, on the date on which such Child is placed with the Employee by an authorized placement agency or by judgment, decree, or other order of a court of competent jurisdiction;
4. For a birth, on the date of birth;
5. For an adoption or placement for adoption, on the date of the adoption, or placement for adoption.
6. In the case of an individual who meets the definition under Child of "Any Other Dependent", coverage will be effective on the date of acquisition; and
7. In the case of a Grandchild, benefits will be effective on the first of the month following the date the Child is eligible for coverage.

Additional Special Enrollment Rights
Employees and Dependents who are eligible but not enrolled are entitled to enroll under the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e., CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or
2. The Employee or Dependent becomes eligible for a contribution assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e., CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first of the month following the date of loss of other coverage.

Open Enrollment
"Open Enrollment Period" shall mean the time period determined by the Plan Administrator. The Plan Administrator retains discretionary authority to hold open enrollment during the months of July and August in each Plan Year. Coverage for anyone newly enrolled during the Open Enrollment period will be effective on the subsequent September 1st.

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

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

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

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

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

1. Name of an issuing State child support enforcement agency;
2. Name and mailing address (if any) of an Employee who is a Participant under the Plan or eligible for enrollment;
3. Name and mailing address of each of the Alternate Recipients (i.e., the Child or children of the Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying Child support order.

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

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

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

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

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and Eligible Participants without regard to this section, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

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

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

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

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:

    a. Whether the Child is covered under the Plan; and
    b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage; and

2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

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

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

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

Acquired Companies
Eligible Employees of an acquired company who are Actively at Work and were covered under the Prior Plan of the acquired company will be eligible for the benefits under this Plan on the date of acquisition. Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of the Service Waiting Period of this Plan. In the event that an acquired company did not have a health plan, all eligible Employees will be eligible on the date of the acquisition.

Genetic Information Nondiscrimination Act "GINA"
"GINA" prohibits group health plans, issuers of individual health care policies, and Employers from discriminating on the basis of genetic information.

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

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

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is subject to applicable Privacy and Security Standards.

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

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

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

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

ARTICLE XI - TERMINATION OF COVERAGE

Termination Dates of Individual Coverage
The coverage of any Employee for himself or herself under this Plan will terminate on the earliest to occur of the following dates:

1. The date upon which the Plan is terminated;
2. The last day of the month in, or with respect to which, he or she requests that such coverage be terminated, provided such request is made on or before such date;
3. The last day of the month for which the Employee has contributed, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing;
4. The last day of the month in which he or she ceases to be eligible for such coverage under the Plan;
5. The last day of the month in which the termination of employment occurs; or
6. Immediately when an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Note: If an individual resigns after the end of the instructional year, they will be given the opportunity to continue or decline TSHBP coverage through the remainder of that Plan Year.

Termination Dates of Dependent Coverage
The coverage for any Dependents of any Employee who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. Upon the discontinuance of coverage for Dependents under the Plan;
3. The date of termination of the Employee's coverage for himself or herself under the Plan;
4. The date of the expiration of the last period for which the Employee has contributed, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing;
5. In the case of a Child aged 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:

    a. Cessation of such inability;
    b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; or
    c. Upon the Child's no longer being dependent on the Employee for his or her support;

6. The last day of the month in which he or she loses their status as an eligible Dependent; as defined herein, except as may be provided for in other areas of this section; or
7. Immediately after an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Rescission of Coverage
Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will

result in immediate termination of all coverage under this Plan for the Participant and their entire Family Unit of which the Participant is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30-day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

ARTICLE XII - CONTINUATION OF COVERAGE

Continuation of Coverage During Periods of Employer-Certified Disability, Leave of Absence, Layoff, or Leave Without Pay.

Employer Continuation Coverage
Continuation during periods of Employer-certified to Disability, Leave of Absence, or Layoff or certain other leaves may be available as determined by the Employer. Please refer to the specific districts' policies/handbook for further information regarding the availability of this benefit.

An Employee and his or her covered Dependents may remain eligible for a limited time if Active Full-Time Employment ceases due to Disability, Leave of Absence, or Layoff, until the date the Employer ends the continuance. While coverage is continued, benefits will be that which was in force on the last day worked as an Active Employee. However, in the event benefits are reduced for others in the class, they will also reduce for those individuals covered under the Continuation provisions. For further information, please contact the Plan Sponsor.

Coverage Continuation while on Employer-Approved Leave without Pay
In addition to the Continuation provisions detailed above, in the event that an Employee is on an Employer-approved leave without pay, the Employee must meet the participating district's requirements for leave-without-pay status, including the requirements under the Family and Medical Leave Act. (FMLA). If the Employee is in an approved leave-without-pay status, the eligible Employee may continue TSHBP coverage while on such leave, for a period not to exceed six months. For example, if the Employee works for a participating district that only allows three months of leave without pay, at which time his or her employment is terminated, the employee can continue coverage under TSHBP for three months. If the Employee's participating district allows 12 months of leave without pay, TSHB coverage will end after six months.

Coverage for an individual who qualifies for an Employer-approved leave without pay will end on the earliest of the following dates:

- The last calendar day of the month for which contributions are paid;
- The last calendar day of the month in which the Employee's employment ends;
- The last calendar day of the month in which an individual is no longer eligible for coverage due to requirements unrelated to leave-without-pay status; or
- The last calendar day of the sixth month in which coverage for leave without pay began.

In the event that an Employee returns from an approved leave without-pay which has exceeded the six months timeframe allowed above and returns to Active Employment and further meets eligibility requirements, he or she can re-enroll for TSHBP coverage within 31 days. If the Employee returns to Active Employment within the same Plan Year and chooses to re-enroll in TSHBP, the Employee must select the same plan option in which he or she was previously enrolled. In addition, in the event the Employee has exhausted his or her six months of coverage while on leave without pay, he or she may qualify for Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation of coverage.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor, as well as any applicable state-mandated Family and Medical Leave to the extent that the State leave law is applicable to the Employer and all of its Employees. Leave taken pursuant to any other State leave law shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

If applicable, during any leave taken under the Family and Medical Leave Act and/or other State leave law, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA and/or other State leave law. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA and/or other State leave started and will be reinstated to the same extent that it was in force when that coverage terminated.

Note: This Plan intends to comply with federal requirements for the provision of extensions of coverage under the Family and Medical Leave Act (FMLA), as required. Please contact Plan Sponsor to determine if FMLA benefits are in effect.

Family and Medical Leave Act of 1993 (FMLA)
This applies to Employers with 50 or more Employees within 75 miles, for at least 20 workweeks in the current or preceding Calendar Year. The following are some definitions identified by the FMLA:

Covered Service Member
"Covered Service Member" shall mean current service members and covered veterans who are undergoing medical treatment, recuperation, or therapy due to a serious Injury or Illness, rather than just current service members. A covered veteran is an individual who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to when the eligible Employee takes FMLA Leave to care for the covered veteran.

Eligible Employee
"Eligible Employee" shall mean an individual who has been employed by the Employer for at least 12 months, has performed at least 1250 hours of service during the previous 12-month period, and has worked at a location where at least 50 Employees are employed by the Employer within 75 miles.

Family Member
"Family Member" shall mean the (a) Employee's biological, step, or foster parent or (b) a natural, adopted, foster, or stepchild, or a legal ward under 18 years of age, or 18 years and older and incapable of self-care because of a mental or physical disability or (c) spouse.

Serious Illness or Injury (of a service member or covered veteran)
"Serious Illness or Injury" shall mean an Illness or Injury Incurred in the line of duty that may render the service member medically unfit to perform his or her military duties. A serious Injury or Illness for a current service member includes an Injury or Illness that existed before the beginning of the service member's active duty and was aggravated by service in the line of duty on active duty in the armed forces. A serious Injury or Illness for a covered veteran means an Injury or Illness that was Incurred or aggravated by the service member in the line of duty on active duty in the armed forces and manifested itself before or after the service member became a veteran.

These definitions are listed as a guide and the actual wording of the FMLA, as amended, shall supersede these definitions.

Basic Leave Entitlement
FMLA requires covered Employers to provide up to 12 weeks of unpaid, job-protected leave to eligible Employees for the following reasons:

1. for incapacity due to Pregnancy, prenatal medical care, or Childbirth;
2. to care for the Employee's Child after birth, or placement for adoption or foster care;
3. to care for the Employee's spouse, son, daughter, or parent, who has a serious health condition; or
4. for a serious health condition that makes the Employee unable to perform the Employee's job.

Military Family Leave Entitlements
Eligible Employees whose spouse, son, daughter, or parent is on covered active duty or call to covered active-duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible Employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is:

(1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious Injury or Illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible Employee takes FMLA Leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious Injury or Illness.*

***The FMLA definitions of "serious Injury or Illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition."**

Benefits and Protections
During FMLA Leave, the Employer must maintain the Employee's health coverage under any "group health plan" on the same terms as if the Employee had continued to work. Upon return from FMLA Leave, most Employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA Leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered Employer for at least 12 months, have 1,250 hours of service in the previous 12 months, and if at least 50 Employees are employed by the Employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an Illness, Injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care Provider for a condition that either prevents the Employee from performing the functions of the Employee's job or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care Provider or one visit and a regimen of continuing treatment, or incapacity due to Pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An Employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when Medically Necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the Employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or Employers may require use of accrued paid leave while taking FMLA Leave. In order to use paid leave for FMLA Leave, Employees must comply with the Employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA Leave when the need is foreseeable. When 30 days' notice is not possible, the Employee must provide notice as soon as practicable and generally must comply with an Employer's normal call-in procedures.

Employees must provide sufficient information for the Employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the Employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care Provider, or circumstances supporting the need for military family leave. Employees also must inform the Employer if the requested leave is for a reason for which FMLA Leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered Employers must inform Employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the Employees' rights and responsibilities. If they are not eligible, the Employer must provide a reason for the ineligibility.

Covered Employers must inform Employees if leave will be designated as FMLA-protected and the amount of leave counted against the Employee's leave entitlement. If the Employer determines that the leave is not FMLA-protected, the Employer must notify the Employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any Employer to:

1. interfere with, restrain, or deny the exercise of any right provided under FMLA; and
2. discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An Employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an Employer.

FMLA does not affect any Federal or State law prohibiting discrimination or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered Employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:

1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
https://www.dol.gov/whd/U.S. Department of Labor Wage and Hour Division
WHD Publication 1420 Revised February 2013

Continuation During USERRA
Participants who are absent from employment because they are in the Uniformed Services, and who are on active military duty, must be offered the right to continue health care benefits. If the military leave orders are for a period of 30 days or less, Participants cannot be required to pay more than the normal Participant contribution amount. After this period, Participants may elect to continue their coverage under this Plan for up to 24 months and Participants cannot be required to pay more than 102 percent of the full contribution amount during that time.

To continue coverage, Participants must comply with the terms of the Plan, including election during the Plan's annual enrollment period, and pay their contributions, if any. In addition, USERRA also requires that, regardless of whether a Participant elected to continue his or her coverage under the Plan, his or her coverage and his or her Dependents' coverage be reinstated immediately upon his or her return to employment, so long as he or she meets certain requirements contained in USERRA. Participants should contact their participating Employer for information concerning their eligibility for USERRA and any requirements of the Plan.

Continuation During COBRA – Introduction
The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participant's family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if the Participant or their covered Dependents fail to make timely payment of contributions. Participants should check with their Employer to see if COBRA applies to them and/or their covered Dependents.

Participants may have other options available when group health coverage is lost. For example, a Participant may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, the Participant may qualify for lower costs on his or her monthly contributions and lower out-of-pocket costs. Participants can learn more about many of these options at www.healthcare.gov. Additionally, the Participant may qualify for a 30-day special enrollment period for another group health plan for which the Participant is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA Continuation Coverage
"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if a part of the Employer's plan) are not considered for continuation under COBRA.

Qualifying Events
A qualifying event is any of those listed below if the Plan provided that the Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of COBRA continuation coverage. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Participant." The Employee, the Employee's spouse, and the Employee's Dependent Children could become Qualified Participants if coverage under the Plan is lost because of the Qualifying Event.

A covered Employee (meaning an Employee covered under the Plan) will become a Qualified Participant if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced; or
2. Employment ends for any reason other than gross misconduct.

The spouse of a covered Employee will become a Qualified Participant if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The spouse dies;
2. The spouse's hours of employment are reduced;
3. The spouse's employment ends for any reason other than his or her gross misconduct;
4. The spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. The spouse becomes divorced or legally separated (as allowed by applicable state law) from his or her spouse.

Dependent Children will become Qualified Participants if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-covered Employee dies;
2. The parent-covered Employee's hours of employment are reduced;
3. The parent-covered Employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The parents become divorced or legally separated (as allowed by applicable state law); or
6. The Child stops being eligible for coverage under the Plan as a Dependent Child.

Employer Notice of Qualifying Events
When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the Qualifying Event.

Employee Notice of Qualifying Events
Each covered Employee or Qualified Participant is responsible for providing the COBRA Administrator with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

1. Notice of the occurrence of a Qualifying Event that is a divorce or Legal Separation (as allowed by applicable state law) of a covered Employee (or former Employee) from his or her spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan;
3. Notice of the occurrence of a second Qualifying Event after a Qualified Participant has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;
4. Notice that a Qualified Participant entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of COBRA Continuation Coverage; and
5. Notice that a Qualified Participant, with respect to whom a notice described above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The COBRA Administrator is:

90 Degree Benefits
Attn: COBRA Department
11467 Huebner Rd.
Suite 300
San Antonio, Texas 78230

A form of notice is available, free of charge, from the COBRA Administrator and must be used when providing the notice.

Deadline for providing the notice
For Qualifying Events described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;
2. The date on which the Qualified Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
3. The date on which the Qualified Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

For the disability determination described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date of the disability determination by the SSA;
2. The date on which a Qualifying Event occurs;
3. The date on which the Qualified Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
4. The date on which the Qualified Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

In any event, this notice must be furnished before the end of the first 18 months of COBRA Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Participant is no longer disabled; or
2. The date on which the Qualified Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

The notice must be postmarked (if mailed) or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the person is electing COBRA Continuation Coverage, his or her coverage under the Plan will terminate on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

Who Can Provide the Notice
Any individual who is the covered Employee (or former Employee), a Qualified Participant with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee (or former Employee) or Qualified Participant, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Participants with respect to the Qualifying Event.

Required Contents of the Notice
The notice must contain the following information:

1. Name and address of the covered Employee or former Employee;
2. Identification of the initial Qualifying Event and its date of occurrence, if the person is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period;
3. A description of the Qualifying Event (for example, divorce, Legal Separation (as allowed by applicable state law), cessation of Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Participant or loss of disability status);
4. In the case of a Qualifying Event that is divorce or Legal Separation (as allowed by applicable state law), name(s) and address(es) of spouse and Dependent child(ren) covered under the Plan, date of divorce or Legal Separation (as allowed by applicable state law), and a copy of the decree of divorce or Legal Separation (as allowed by applicable state law);
5. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former Employee, date of entitlement, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan;
6. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age);
7. In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan;
8. In the case of a Qualifying Event that is disability of a Qualified Participant, name and address of the disabled Qualified Participant, name(s), and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Participant who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
10. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or Legal Separation (as allowed by applicable state law) or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or Legal Separation (as allowed by applicable state law) or the SSA's determination within 30 days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or Legal Separation (as allowed by applicable state law) or the SSA's determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified by the COBRA Administrator in the request, the COBRA Administrator may reject the notice if it does not contain enough information for the COBRA Administrator to identify the plan, the covered Employee (or former Employee), the Qualified Participants, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the COBRA Administrator within 14 days of receiving the notice of the Qualifying Event. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Participant will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their Children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

Waiver Before the End of the Election Period

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

Duration of COBRA Continuation Coverage

COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36-month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or Legal Separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the covered Employee's hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Participants other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

Disability Extension of COBRA Continuation Coverage
If an Employee or anyone in an Employee's family covered under the Plan is determined by the SSA to be disabled and the Employee notifies the COBRA Administrator as set forth above, the Employee and his or her entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Second Qualifying Event Extension of COBRA Continuation Coverage
If an Employee's family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the spouse and Dependent Children in the family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the spouse and any Dependent Children receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

Shorter Duration of COBRA Continuation Coverage
COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date the Employer ceases to provide a group health plan to any Employee;
2. The date on which coverage ceases by reason of the Qualified Participant's failure to make timely payment of any required contributions;
3. The date that the Qualified Participant first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first) (except as stated under COBRA's special bankruptcy rules); or
4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Participant is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Contribution Requirements
Once COBRA Continuation Coverage is elected, the individual must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Trade Reform Act and Further Consolidated Appropriations Act, 2020
The Further Consolidated Appropriations Act, 2020 has extended certain provisions of the Trade Reform Act, which created a special COBRA right applicable to certain employees who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance." These individuals can either take a Health Coverage Tax Credit (HCTC) or get advance payment of the applicable percentage of contributions paid for qualified health benefits coverage, including COBRA continuation coverage. These individuals are also entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the individual becomes eligible for assistance under the Trade Reform Act. However, this election may not be made more than six months after the date the individual's group health plan coverage ends.

A Participant's eligibility for subsidies under the Further Consolidated Appropriations Act, 2020, affects his or her eligibility for subsidies that provide assistance for coverage purchased through the Health Insurance Marketplace. For each coverage month, a Participant must choose one or the other, and if he or she receives both during a tax year, the IRS will reconcile his or her eligibility for each subsidy through his or her individual tax return. Participants may wish to consult their individual tax advisors concerning the benefits of using one subsidy or the other.

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

Additional Information
Additional information about the Plan and COBRA Continuation Coverage is available from the COBRA Administrator, who is:

90 Degree Benefits
Attn: COBRA Department
11467 Huebner Rd.
Suite 300
San Antonio, Texas 78230

Current Addresses
In order to protect the rights of the Employee's family, the Employee should keep the COBRA Administrator (identified above) informed of any changes in the addresses of family members.

ARTICLE XIII - GENERAL LIMITATIONS AND EXCLUSIONS

This section applies to all benefits provided under any section of this Plan. This Plan does not cover any charge for care, supplies, treatment, and/or services:

Custodial Care. That do not restore health or are provided mainly as a rest cure or for maintenance care, unless specifically mentioned otherwise.

Error. That are required to treat injuries that are sustained or an Illness that is contracted, including infections and complications, while the Participant was under, and due to, the care of a Provider wherein such Illness, Injury, infection, or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense.

Excess. That exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

Experimental. That are Experimental or Investigational.

Family Member. That are performed by a person who is related to the Participant as a spouse, parent, Child, brother, or sister, whether the relationship exists by virtue of "blood" or "in law."

Foreign Travel. Services received while traveling if travel is for the sole purpose of obtaining medical benefits.

Government. That are expenses to the extent paid, or which the Participant is entitled to have paid or obtain without cost, in accordance with the laws or regulations of any government.

Government-Operated Facilities.

1. Services furnished to the Participant in any veterans Hospital, military Hospital, Institution, or facility operated by the United States government or by any State government or any agency or instrumentality of such governments.
2. Services or supplies which can be paid for by any government agency, even if the patient waives his rights to those services or supplies.

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

Hazardous Hobbies for Cash or Prize Money - Excludes charges incurred as a result of engaging in a hazardous hobby for cash compensation or prize money.

Note: Exclusion does not apply to any expenses incurred for the treatment of Illness or Injury sustained as a result of rodeoing.

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

Incurred by Other Persons. For expenses actually Incurred by other persons.

Ineligible Procedure. Incurred due to an ineligible procedure.

Medical Necessity. That are not Medically Necessary.

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

Negligence. For Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice on the part of any licensed Physician.

No Legal Obligation. That are provided to a Participant for which the Provider of a service customarily makes no direct charge, or for which the Participant is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including but not limited to fees, care, supplies, or services for which a person, company or any other entity except the Participant or this benefit plan, may be liable for necessitating the fees, care, supplies, or services.

Not Acceptable. That are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).

Not Actually Rendered. That are not actually rendered.

Not Specifically Covered. That are not specifically covered under this Plan.

Occupational. For any condition, Illness, Injury, or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit. Participants that are self-employed or employed by an employer that does not provide health benefits should ensure they have other medical benefits to provide for medical care in the event they are hurt on the job. In most cases workers' compensation insurance will cover the costs, but if the Participant does not have such coverage, he or she may end up with no coverage at all. The claim would be considered if the claim is denied by workers' compensation.

Other than Attending Physician. Other than those certified by a Physician who is attending the Participant as being required for the treatment of Injury or Illness and performed by an appropriate Provider.

Prior to Coverage. That are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

Prohibited by Law. To the extent that payment under this Plan is prohibited by law.

Provider Error. Required as a result of unreasonable Provider error.

Self-Inflicted. That are the result of intentionally self-inflicted Injuries or Illnesses. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Subrogation, Reimbursement, and/or Third-Party Responsibility. Of an Injury or Illness not payable by virtue of the Plan's subrogation, reimbursement, and/or third-party responsibility provisions.

War. That are Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression, when the Participant is a member of the armed forces of any Country, or during service by a Participant in the armed forces of any Country. This Exclusion does not apply to any Participant who is not a member of the armed forces.

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

ARTICLE XIV - PLAN ADMINISTRATION

The Plan Administrator has been granted the authority to administer the Plan. The Plan Administrator has retained the services of the Third-Party Administrator to provide certain claims processing and other technical services. The claims processing and other technical services delegated to the Third-Party Administrator notwithstanding, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency, and making factual determinations.

Plan Administrator
The Plan is administered by the Plan Administrator in accordance with these provisions. An individual, committee, or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the appointed Plan Administrator or a committee member resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

Discretionary Authority
The Plan is administered by the Plan Administrator (which may be the Plan Sponsor, or another entity appointed by the Plan Sponsor for this purpose). The Plan Administrator (or the PACE insofar as it relates to Final Post-Service Appeals) shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan. The Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, reserves the right to allocate certain discretionary authority as it applies to assessment and final determinative authority on and regarding Final Post-Service Appeal[s], to the "PACE."

The PACE's fiduciary duties extend only to those determinations actually made by the PACE, and with which the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan complies. An entity that may perform services as the PACE may perform other tasks on behalf of, and in consultation with, the Plan Administrator and/or Plan Sponsor, but not as the PACE, and the PACE shall only be deemed to be a fiduciary when making final determinations regarding plan coverage and claims examined via Final Post-Service Appeal. The Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed to act on behalf of the Plan, is prohibited from referring to the PACE, in accordance with applicable law and/or pre-existing contract, in all other matters, including but not limited to, other appeals that are "not" Final Post-Service Appeals.

The PACE shall at all times strictly abide by, and make determination(s) in accordance with, the terms of the Plan and applicable law. In instances where the Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, delegates fiduciary authority to the PACE to make a determination regarding a Final Post-Service Appeal, the PACE shall have discretion to interpret the terms of this Plan, and the PACE possesses all duties and rights otherwise ascribed to the Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, in this limited scope only. In such instances, the PACE's determinations will be final and binding on all interested parties, and failure to comply with said determination by the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan, shall absolve the PACE of any and all fiduciary (and other) liability, responsibility, obligations, and/or duties.

The Plan shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Participant is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

Duties and Rights of the PACE

When the PACE is assigned by the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan, the task of making a determination regarding a Final Post-Service Appeal, the PACE shall possess the rights and exercise the duties otherwise ascribed to the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, only insofar as it relates to said Final Post-Service Appeals. Assignment is achieved by and when the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan advances a request for a Final Post-Service Appeal, received by the Plan or its authorized agent(s), to the PACE with instructions to provide a directive regarding the Final Post-Service Appeal.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status, and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Participant's rights and/or availability of benefits;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a Third-Party Administrator to pay claims;
9. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO;
10. To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate; and
11. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend, or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the trust agreement (if any). All amendments to this Plan shall become effective as of the date established by the Plan Sponsor.

Any amendment to the Plan that is not made effective at the beginning of a normal Plan Year by integration into a full Plan Document restatement, including suspension and/or termination, shall follow the amendment procedure outlined in this section. The amendment procedure is accomplished by a separate, written amendment decided upon and/or enacted by resolution of the Plan Sponsor's directors or officers (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or by the sole proprietor in his or her own discretion if the Plan Sponsor is a sole proprietorship, but always in accordance with applicable Federal and State law.

If the Plan is terminated, the rights of the Participants are limited to expenses Incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for Covered Expenses Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. As it relates to distribution of assets upon termination of the Plan, any contributions paid by Participants will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration and will not inure to the benefit of the Employer.

Summary of Material Modification (SMM)
A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to Copayments, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Material Modification by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective. If said Material Modification is affected by amendment as described above, distribution of a copy of said written amendment, within all applicable time limits, shall be deemed sufficient notification to satisfy the Plan's Summary of Material Modifications requirements.

Note: The Affordable Care Act (ACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Participants at least 60 days before the effective date of the Material Modification.

Summary of Material Reduction (SMR)
A Summary of Material Reduction (SMR) is a type of SMM. A Material Reduction generally means any modification that would be considered by the average participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in coinsurance or copayments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Participant. The 60-day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

If said Material Reduction is affected by amendment as described above, distribution of a copy of said written amendment, within all applicable time limits, shall be deemed sufficient notification to satisfy the Plan's Summary of Material Reduction requirements.

Material Reduction disclosure provisions are subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

Misuse of Identification Card
If an Employee or covered Dependent permits any person who is not a covered member of the Family Unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated in accordance with the Plan's provisions.

ARTICLE XV - CLAIM PROCEDURES; PAYMENT OF CLAIMS

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

Health Claims
Full and final authority to adjudicate claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan, and applicable law. To receive due consideration, claims for benefits and questions regarding said claims should be directed to the Third-Party Administrator. The Plan Administrator may delegate to the Third-Party Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The Third-Party Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

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

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

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

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Nonurgent), Concurrent Care and Post service. However, as noted below, because of this Plan's design, there are no Preservice Urgent Care Claims which may be filed with the Plan.

1. Pre-service Claims. A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. However, if the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

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

   If a Participant needs medical care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

   The Plan does not require the Participant to obtain approval of any urgent care or Emergency medical services or admissions prior to getting treatment for an urgent care or Emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Participant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

    a. The Plan determines that the course of treatment should be reduced or terminated; or
    b. The Participant requests extension of the course of treatment beyond that which the Plan has approved.

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

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

When Claims Must Be Filed

Post-service health claims must be filed with the Third-Party Administrator within 12 months of the date charges for the service were Incurred. Claims filed later than that date shall be denied. Benefits are based upon the Plan's provisions at the time the charges were Incurred.

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is received by the Third-Party Administrator in accordance with the Plan's procedures.

A post-service claim is considered to be filed when the following information is received by the Third-Party Administrator, together with the industry standard claim form:

1. The date of service.
2. The name, address, telephone number and tax identification number of the Provider of the services or supplies.
3. The place where the services were rendered.
4. The Diagnosis and procedure codes.
5. Any applicable pre-negotiated rate.
6. The name of the Plan.
7. The name of the covered Employee.
8. The name of the patient.

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

Timing of Claim Decisions

The Plan Administrator shall notify the Participant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Urgent Care Claims:

    a. If the Participant has provided all of the necessary information, as soon as possible, considering the medical exigencies, but not later than 72 hours after receipt of the claim.
    b. If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
    c. The Participant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, considering the medical exigencies, after the earliest of:

        i. The Plan's receipt of the specified information; or
        ii. The end of the period allowed to the Participant to provide the information.

    d. If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Participant may request an expedited review under the external review process.

2. Pre-service Non-urgent Care Claims:

    a. If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
    b. If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible. The Participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Participant (if additional information was requested during the extension period).

3. Concurrent Claims:

    a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), notification will occur before the end of such period of time or number of treatments. The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
    b. Request by Participant Involving Urgent Care. If the Plan Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, considering the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Participant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

c. Request by Participant Involving Non-Urgent Care. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).
d. Request by Participant Involving Rescission. With respect to rescissions, the following timetable applies:

i. Notification to Participant	30 days
ii. Notification of Adverse Benefit Determination on appeal	30 days

4. Post-service Claims:

a. If the Participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
b. If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.

5. Extensions:

a. Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
b. Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day processing period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
c. Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

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

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. A reference to the specific portion(s) of the Plan Document upon which a denial is based;
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
4. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;
5. A description of the Plan's review procedures and the time limits applicable to the procedures;

6. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;
7. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
8. Any rule, guideline, protocol, or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Participant, free of charge, upon request);
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided to the Participant, free of charge, upon request.
10. In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

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

1. A 180-day timeframe following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. The Plan will not accept appeals filed after a 180-day timeframe;
2. Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. Participants the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.
4. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
5. For a review that considers all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;
7. Upon request, the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;
8. If applicable, a discussion of the basis for disagreeing with the disability determination made by either (a) the Social Security Administration; or (b) an independent medical expert that has conducted a full medical review of the Claimant if presented by the Claimant in support of the claim.
9. That a Participant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Participant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances; and
10. That a Participant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Participant to respond to such new evidence or rationale.

Requirements for First Level Appeal
The Participant must file the appeal in writing (although oral appeals are permitted for pre-service urgent care claims) within 180 days following receipt of the notice of an Adverse Benefit Determination. For pre-service urgent care claims, if the Participant chooses to orally appeal, the Participant may telephone:

90 Degree Benefits
Phone: 1 (888) 803-0081

Oral appeals should be submitted in writing as soon as possible after it has been initiated.

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

90 Degree Benefits
P.O. Box 21548
Eagan, MN 55121
E-mail: careconnect@90degreebenefits.com
Fax: 1 (806) 698-5823

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

1. The name of the Employee/Participant;
2. The Employee/Participant's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

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

1. Pre-service Urgent Care Claims: As soon as possible, considering the medical exigencies, but not later than 72 hours after receipt of the appeal.
2. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim: Pre-service Urgent, Pre-service Non-urgent or Post-service.
4. Post-service Claims: Within a reasonable period of time, but not later than 30 days per internal appeal.

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

Manner and Content of Notification of Adverse Benefit Determination on Review

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

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

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

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

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

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

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

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

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

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a Participant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.

2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.

3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

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

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

    a. The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
    b. The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
    c. The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the final regulations; and
    d. The claimant has provided all the information and forms required to process an external review. Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the

request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external review. Moreover, the Plan will act against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Third-Party Administrator to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:

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

Exhaustion of Internal Claims Procedures

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

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the claimant of its eligibility determination.

3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available, and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard

review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

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

Appointment of Authorized Representative
A Participant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Participant to a Provider will not constitute appointment of that Provider as an authorized representative. To appoint such a representative, the Participant must complete a form which can be obtained from the Plan Administrator or the Third-Party Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Participant's medical condition to act as the Participant's authorized representative without completion of this form. In the event a Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs the Plan Administrator, in writing, to the contrary.

Autopsy
The Plan reserves the right to have an autopsy performed upon any deceased Participant whose condition, Illness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

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

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

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

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

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

1. Benefits may not be assigned to a Non-U.S. Provider;
2. The Participant is responsible for making all payments to Non-U.S. Providers, and submitting receipts to the Plan for reimbursement;
3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred Date;
4. The Non-U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements;
5. Claims for benefits must be submitted to the Plan in English; and
6. Travel outside the U.S. cannot be for the express (sole) purpose of obtaining medical care.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations, or Exclusions, or should otherwise not have been paid by the Plan. As such, this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Participant or Dependent on whose behalf such payment was made.

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

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

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

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

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

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

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

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

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

Limitation of Action
A Claimant cannot bring any legal action against the Plan for a claim of benefits until 90 days after all appeal processes have been exhausted. After 90 days, if the Claimant wants to bring a legal action against the Plan, he or she must do so within 1 year of the date he or she is notified of the final decision on the final appeal, or he or she will lose any rights to bring such an action against the Plan.

ARTICLE XVI - COORDINATION OF BENEFITS

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

Excess Coverage
If at the time of Injury or Illness or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible:

1. Any primary payer besides the Plan;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation
When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies and will exclude benefits subject to the Exclusions in this Plan up to the maximum amount available to the Participant under applicable state law, regardless of a Participant's election of lesser coverage amount. This applies to all forms of medical payments under vehicle plans and/or policies regardless of their names, titles, or classifications.

Allowable Expense(s)
"Allowable Expense(s)" shall mean the Maximum Allowable Charge for any Medically Necessary, and eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations section herein, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made, therefore.

"Claim Determination Period"
"Claim Determination Period" shall mean each Plan Year.

Effect on Benefits

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

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

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

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

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

1. A plan without a coordinating provision will always be the primary plan;

2. If an individual is covered under one plan as a dependent and another plan as an employee, member or subscriber, the plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) is considered primary. The primary plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any Employee plan beneficiary to be eligible for primary benefits from his or her Employer's benefit plan.

3. The plan that covers a person as a dependent is generally secondary. The plan that covers a person as a dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a dependent. See the section on Medicare below for exceptions to this rule.

4. If an individual is covered under a spouse's plan and also under his or her parent's plan, the primary plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the secondary plan.

5. If one or more plans cover the same person as dependent child:

   ➢ The primary plan is the plan of the parent whose birthday is earlier in the year if:

   - The parents are married; or
   - The parents are not separated (whether or not they have been married); or
   - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
   - If both parents have the same birthday, the plan that has covered either of the parents the longest is primary.

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

   ➢ If the parents are not married and reside separately, or are divorced or legally separated (whether or not they have ever been married), the order of benefits is;

   - The plan of the custodial parent;
   - The plan of the spouse of the custodial parent;
   - The plan of the non-custodial parent; and then
   - The plan of the spouse of the non-custodial parent.

6. Active or inactive Employee: If an individual is covered under one plan as an active employee (or dependent of an active employee) and is also covered under another plan as a retired or laid off employee (or dependent of a retired or laid off employee), the plan that covers the person as an active employee (or dependent of an active employee) will be primary. This rule does not apply if the rule in the third paragraph above can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

7. Continuation coverage under COBRA or state law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if any of the items from 1 through 4 above apply. (See exception in the Medicare section.)

8. Longer or shorter length of coverage: The plan that covered the person as an employee, member, subscriber, or the retiree the longest is the primary.

9. If an active employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active employee, member, or subscriber is considered primary.

10. If the above rules do not determine the primary plan, the covered expenses may be shared equally between the plans. This plan will not pay more than it would have paid, had it been primary.

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

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

Right of Recovery
In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents. Please the Recovery of Payments provision above for more details.

ARTICLE XVII - MEDICARE

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

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

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Participants Who Are Covered Under This Plan
If any Participant is enrolled in Medicare coverage because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of the Participant's Medicare entitlement, regardless of the date of enrollment, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

ARTICLE XVIII –
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition
The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to crime victim restitution funds, civil restitution funds, no-fault restitution funds (including vaccine injury compensation funds), uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party, any medical, applicable disability, or other benefit payments, and school insurance coverage (collectively "Coverage").

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

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation
As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

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

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any other source of Coverage, including, but not limited to, the following:

    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

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

Right of Reimbursement
The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan. Additionally, the Participant shall indemnify the Plan against any of the Participant's attorney's fees, costs, or other expenses related to the Participant's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, or disability.

Participant is a Trustee Over Plan Assets
Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability
The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) (Incurred) prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

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

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

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

2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.

3. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.

4. Workers' compensation or other liability insurance company.

5. Any other source of Coverage, including, but not limited to, the following:

    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage.

Separation of Funds
Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

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

Obligations
It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Illness, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
9. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
10. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

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

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

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

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

Severability
In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

ARTICLE XIX - MISCELLANEOUS PROVISIONS

Applicable Law
This Plan is a governmental (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a federal law regulating Employee welfare and pension plans. Your rights as a participant in the Plan are governed by the plan documents and applicable State law and regulations. This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, Exclusions, or limitations. Additionally, the Plan will comply with any applicable State PPO prompt pay laws.

Clerical Error/Delay
Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Participants have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

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

Fraud
Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and their entire Family Unit of which the Participant is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30-day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

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

Pronouns
Unless the context otherwise demands, words importing any gender shall be interpreted to mean any or all genders.

Word Usage
Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

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

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

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

Notwithstanding any other provision of the Plan, the Plan Administrator's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Company's obligation with respect to such payments.

In the event that the Company terminates the Plan, then as of the effective date of termination, the Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

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

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

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

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

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

Protection Against Creditors
To the extent this provision does not conflict with any applicable law, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Participant or former Participant, his/her spouse, parent, adult Child, guardian of a minor Child, brother, or sister, or other relative of a Dependent of such Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

Unclaimed Self-Funded Plan Checks
In the event a benefits check issued by the Third-Party Administrator for this self-funded Plan is not cashed within one year of the date of issue, the check will be voided, and the funds will be retained by this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Participant subsequently requests payment with respect to the voided check, the Plan Sponsor for the self-funded Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-funded Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan, pursuant to any applicable State law(s).

ARTICLE XX - HIPAA PRIVACY

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The Participant's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Participant's personal health information. It also describes certain rights the Participant has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling 1 (800) 583-6908.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

How Health Information May Be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out payment of benefits.
2. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.

2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information.
3. Other Covered Entities: The Plan may also disclose or share PHI with other benefit carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. Not use or disclose genetic information for underwriting purposes.
6. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
7. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
8. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).
9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

Required Disclosures of PHI

1. Disclosures to Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Participant.

2. Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Participant's Rights

The Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends, or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Participant has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Officer.
5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he, or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30-day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial.
6. Amendment: The Participant has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.
7. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions, or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Officer Contact Information:

Medical Account Manager
Financial Benefit Services, LLC
2175 N Glenville Drive
Richardson, TX, 75082
Phone: (1) 800 583-6908
Fax: 1 (469) 385-4641
Website: https://tshbp.org/
Email: tshbpprivacyoffice@fbsbenefits.com

Additional Contact Information for HIPAA Questions:

Medical Account Manager
Financial Benefit Services, LLC
2175 N Glenville Drive
Richardson, TX, 75082
Phone: (1) 800 583-6908
Fax: 1 (469) 385-4641
Website: https://tshbp.org/
Email: tshbpprivacyoffice@fbsbenefits.com

ARTICLE XXI - HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality, and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

- **Electronic Protected Health Information (ePHI),** as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents,** as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
7. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

        i. Privacy Officer.
        ii. Director of Employee Benefits.
        iii. Employee Benefits Department employees.
        iv. Information Technology Department.

    The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining contribution bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health benefits policy or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third-Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Resolution of Noncompliance

In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Participant's PHI to the Secretary of the U.S. Department of Health and Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

ARTICLE XXII - DEFINITIONS

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

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

"Accident"
"Accident" shall mean a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

"Accidental Bodily Injury" or "Accidental Injury"
"Accidental Bodily Injury" or "Accidental Injury" shall mean an Injury sustained as the result of an Accident, due to a traumatic event outside traumatic event, or due to exposure to the elements.

"Acquired Brain Injury"
"Acquired Brain Injury" means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

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

"ADA"
"ADA" shall mean the American Dental Association.

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

"Affordable Care Act (ACA)"
The "Affordable Care Act (ACA)" means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

"AHA"
"AHA" shall mean the American Hospital Association.

"Allowable Expense(s)"
"Allowable Expense(s)" shall mean the Maximum Allowable Charge for any Medically Necessary, and eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with the Application to Benefit Determination section herein, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made, therefore.

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

"AMA"
"AMA" shall mean the American Medical Association.

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

"Approved Clinical Trial"
"Approved Clinical Trial" shall mean a phase I, II, III or IV trial that is federally funded by specified Agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or a non-governmental entity identified by NIH guidelines) or is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

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

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

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

"Autism Spectrum Disorder" means a neurobiological disorder that includes autism, Asperger's syndrome, or pervasive developmental disorder--not otherwise specified. A neurobiological disorder means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

"Brand Name Drug"
"Brand Name/Brand Name Drug" shall mean a trade name medication.

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

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

"Cardiac Rehabilitation"
"Cardiac Rehabilitation" means a program that demonstrates and accomplishes a reduction, statistically, in 5 or more of the following measures for patients from their levels before the starting of the program:

a. Low density lipoprotein level
b. High density lipoprotein level
c. Body mass index
d. Systolic blood pressure;
e. Diastolic blood pressure;
f. Hemoglobin A1c (if diabetic) level closer or below 7%
g. Compliance with the use of medications for lipids, blood pressure, antiplatelets, diabetes and related conditions.

Additionally, a Cardiac Rehabilitation program must have a physician immediately available and accessible for medical consultations and emergencies.

"Case Manager"
"Case Manager" the person, who develops, coordinates, and implements a plan of care unique to the needs of the Participant. The Case Manager may be (1) made available through the Plan Administrator, or (2) a separate entity with a direct contractual relationship with the Plan.

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

"Child" and/or "Children"
"Child" shall mean, in addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an "eligible foster Child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship. A "legal guardian" is a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

In addition, the following will also be considered covered Dependents:

- A Grandchild under the age of 26 whose primary residence is the household of the Employee and who is a Dependent of the Employee for Federal Income Tax purposes for the reporting year in which coverage of the grandchild is in effect.

- "Any Other Dependent" (other than those listed above) under the age of 26 in a regular parent-child relationship with the employee, meeting all four of the following requirements:
    - The Child's primary residence is the household of the Employee;
    - The Employee provides at least 50% of the Child's support;
    - Neither of the Child's natural parents resides in that household;
    - For Dependents under the age of 18, the Employee has the right to make decisions regarding the Child's medical care.

Note: A Dependent does not include a brother or a sister of an Employee unless the brother or sister is an individual under 26 of age who is either (1) under the legal guardianship of the Employee, or (2) in a regular parent–child relationship with the Employee, as defined in the "any other child" category above. Parents and Grandparents of the covered employee do not meet the definition of an Eligible Dependent.

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

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

"Chiropractic Care"
"Chiropractic Care" shall mean the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal (vertebrae) column.

"Claim Determination Period"
"Claim Determination Period" shall mean each Plan Year.

"Claimant"
"Claimant" shall mean a participant of the Plan, or entity acting on the participant's behalf, authorized to submit claims to the Plan for processing, and/or appeal an Adverse Benefit Determination.

"Clean Claim"
A "Clean Claim" is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity or other coverage criteria, or fees under review for application of the Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments, including but not limited to W-9's, etc., and additional elements or revisions to data elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Participant has failed to submit required forms or additional information to the Plan as well.

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

"Cognitive Communication Therapy"
"Cognitive Communication Therapy" means services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

"Cognitive Rehabilitation Therapy"
"Cognitive Rehabilitation Therapy" means services designed to address therapeutic cognitive activities, based on an assessment, and understanding of the individual's brain-behavioral deficits.

"Coinsurance"
"Coinsurance" means the shared financial responsibility for covered expenses between the Participant and this Plan, expressed as a percentage.

"Community Reintegration Services"
"Community Reintegration Services" means services that facilitate the continuum of care as an affected individual transitions into the community.

"Compound Drug" shall mean: a prescription that includes two or more solid, semi-solid or liquid ingredients, one of which must be a covered drug that are mixed together according to a prescriber's order and adjudicated under NCPDP D.01 protocols.

Note: This Plan requires that all compound medications must be obtained through an accredited compounding pharmacy.

"Copay"
"Copay" or "Copayment" means the amount a Participant must pay each time certain covered services are provided, as outlined in the Schedule of Benefits.

"Copayment Maximum / Out-of-Pocket Maximum"
"Copayment Maximum / Out-of-Pocket Maximum" shall mean the total Deductible and Copay amounts for certain covered services that are a Participant's responsibility during a Plan Year. The Deductible requirements and Copayment Maximums are listed in the Schedule of Benefits. When the Copayment Maximum / Out-of-Pocket Maximum is met, this Plan will pay one hundred (100%) percent of the covered charges for certain covered services incurred during the remainder of the Plan Year.

The Copayment Maximum / Out-of-Pocket Maximum renews each consecutive Plan Year. The following amounts are not considered or considered with respect to the Copayment Maximum / Out-of-Pocket Maximum: charges that are not covered services under this Plan, charges which exceed the Maximum Allowable Charge, costs paid by the covered individual as a result of failure to comply with pre-certification or other review requirements, and charges in excess of applicable Plan maximums.

"Cosmetic Surgery"
"Cosmetic Procedure/Cosmetic Surgery" shall mean any Surgery, service, Drug, or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal, but which may be considered unpleasing or unsightly, except for correction of abnormal congenital conditions and reconstructive surgery when necessitated by treatment of an Injury or Illness.

"Covered Expense(s)"
"Covered Expense(s)" means the Maximum Allowable Charge for a Medically Necessary service, treatment, or supply, meant to improve a condition or participant's health, which is eligible for coverage in this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

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

"Covered Expense" or "Covered Service"
"Covered Expense" or "Covered Service" is a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Payable Amount. It means the Maximum Allowable Charge for a Medically Necessary service, treatment, or supply, meant to improve a condition or participant's health, which is eligible for coverage in this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

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

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

"Deductible"
"Deductible" is a specified dollar amount that must be satisfied, either individually or combined as a covered family, per Plan Year before this Plan pays benefits for certain specified services.

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

1. An Employee's lawfully married spouse possessing a marriage license who is not divorced from the Employee. The term "spouse" shall mean the person recognized as the Employee's lawfully married spouse under the Code and the laws of the state or county where the marriage ceremony occurred. The Plan Administrator may require documentation proving a legal marriage relationship;
2. An Employee's common law spouse, based upon a common law marriage which is legally recognized in the jurisdiction in which the Employee has his or her principal residence (A common law spouse is not considered eligible unless there is a Declaration of Informal Marriage filed with an authorized government agency);
3. An Employee's Child until the end of the calendar month in which they attain 26 years of age; or
4. An Employee's Child, regardless of age, who was continuously covered prior to attaining the limiting age in the numbers above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age in the numbers above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age under the bullets above. The deadline for submission of written proof of incapacity and dependency is 31 days following the original eligibility date for a new or re-enrolling Employee. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two-year period, the Plan may require such proof, but not more often than once each year.

"Dependent" does not include any person who is an active-duty member of the armed forces of any Country or who is a resident of a Country outside the United States. The Plan reserves the right to require documentation satisfactory to the Plan Administrator, which establishes a Dependent relationship.

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

"Diagnosis"
"Diagnosis" shall mean the act or process of identifying or determining the nature and cause of an Illness or Injury through evaluation of patient history, examination, and review of laboratory data. Diagnosis shall also mean the findings resulting from such act or process.

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

"Drug"
"Drug" shall mean insulin and prescription legend Drugs. A prescription legend Drug is a Federal legend Drug (any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription") or a State restricted Drug (any medicinal substance which may be dispensed only by prescription, according to State law) and which, in either case, is legally obtained from a licensed Drug dispenser only upon a prescription of a currently licensed Physician.

"Durable Medical Equipment"
"Durable Medical Equipment" shall mean equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally, is not useful to a person in the absence of an Illness or Injury; and
4. Is appropriate for use in the home.

"Emergency"
"Emergency" shall mean a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

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

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

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

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished,

until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

"Employee"
"Employee" shall mean a person who is employed by a participating district and is Actively at Work, a contributing TRS pension fund member, and meets all eligibility guidelines as specified.

"Employer"
"Employer" is a participating school district in the Texas Schools Health Benefits Program.

"Essential Health Benefits"
"Essential Health Benefits" shall mean, under section 1302(b) of the Affordable Care Act (ACA), those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription Drugs; rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

The determination of which benefits provided under the plan are Essential Health Benefits shall be made in accordance with the benchmark plan of the State of Utah, as permitted by the Departments of Labor, Treasury, and Health and Human Services.

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

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

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

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

1. If the Drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the Drug or device is furnished;
2. If reliable evidence shows that the Drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:

    a. maximum tolerated dose;
    b. toxicity;
    c. safety;
    d. efficacy; and
    e. efficacy as compared with the standard means of treatment or Diagnosis; or

3. If reliable evidence shows that the consensus among experts regarding the Drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:

a. maximum tolerated dose;
b. toxicity;
c. safety;
d. efficacy; and
e. efficacy as compared with the standard means of treatment or Diagnosis.

Reliable evidence shall mean:

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

Notwithstanding the above, a prescription Drug for a treatment that has been approved by the Food and Drug Administration (FDA) but is used as a non-approved treatment shall not be considered Experimental/Investigational for purposes of this Plan and shall be afforded coverage to the same extent as any other prescription Drug; provided that the Drug is recognized by one of the following as being Medically Necessary for the specific treatment for which it has been prescribed:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or
4. A clinical study or review article in a reviewed professional journal.

Subject to a medical opinion, if no other FDA approved treatment is feasible and as a result the Participant faces a life-or-death medical condition, the Plan Administrator retains discretionary authority to cover the services or treatment.

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

Explanation of Benefits (EOB)
"Explanation of Benefits" shall mean a statement a health plan sends to a Participant which shows charges, payments and any balances owed. It may be sent by mail or e-mail. An Explanation of Benefits may serve as an Adverse Benefit Determination.

"Family Unit"
"Family Unit" shall mean the Employee, his or her spouse and Children.

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

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

"FMLA"
"FMLA" shall mean the Family and Medical Leave Act of 1993, as amended.

"FMLA Leave"
"FMLA Leave" shall mean a Leave of Absence, which the Company is required to extend to an Employee under the provisions of the FMLA.

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

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

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

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

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

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

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

1. Is approved as a Home Health Care Agency under Medicare;
2. Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
3. Meets all of the following requirements:

    a. It is an agency which holds itself forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home;
    b. It has a full-time administrator;
    c. It maintains written records of services provided to the patient;
    d. Its staff includes at least one Registered Nurse (R.N.), or it has nursing care by a Registered Nurse (R.N.) available; and
    e. Its Employees are bonded, and it provides malpractice insurance.

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

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

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution has the appropriate accreditation as such a facility.

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

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

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

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

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

"Injury"
"Injury" shall mean an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

"Inpatient"
"Inpatient" shall mean any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for Room and Board is made by the Hospital.

Institutes of Excellence ™ (IOE) Network
IOE Network is a special Network of Hospitals that specialize in organ and bone marrow/stem cell transplants. An Institute of Excellence is a participating facility that has been contracted by Aetna for specific transplant types. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

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

"Intensive Care Unit"
"Intensive Care Unit" shall have the same meaning set forth in the definition of "Cardiac Care Unit."

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

"Leave of Absence"
"Leave of Absence" shall mean a Leave of Absence of an Employee that has been approved by his or her Participating Employer, as provided for in the Participating Employer's rules, policies, procedures, and practices.

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

"Major Diagnostic Procedures"
"Major Diagnostic Procedures" means X-rays and other diagnostic procedures not commonly performed in an office setting including, but not limited to the following: Bone Scans, Cardiac Stress Tests, CT Scans, Nuclear Medicine, MRI's, Myelography, PET Scans, and Angiography.

"Mastectomy"
"Mastectomy" shall mean the surgical removal of all or part of a breast.

"Maximum Allowable Charge"
The "Maximum Allowable Charge" shall mean the benefit payable for a specific coverage item or benefit under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists; if no negotiated rate exists, the Maximum Allowable Charge will be determined by the Plan to be the Medicare reimbursement rates presently utilized by the Centers for Medicare and Medicaid Services ("CMS") either multiplied by 150% for Facility fees or 130% for Professional expenses or multiplied by a percentage that the particular Provider and/or others in the area customarily accept from all payers.

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

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

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

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

With respect to Non-Network Emergency Services, the Plan allowance is the greater of:

- If applicable, the negotiated amount for In-Network Providers (the median amount if more than one amount to In-Network Providers).
- The Plan's normal Non-Network payable amount after consideration of the criteria described below (reduced for cost-sharing).
- The amount that Medicare Parts A or B would pay (reduced for cost-sharing).

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

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

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

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

"Medical Record Review"
"Medical Record Review" is the process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a Drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

"Medically Necessary"
"Medically Necessary", "Medical Necessity" and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Participant for the purposes of evaluation, Diagnosis or treatment of that Participant's Illness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the Diagnosis or treatment of the Participant's Illness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the

Diagnosis or treatment of the Participant's Illness or Injury without adversely affecting the Participant's medical condition.

1. Its purpose must be to restore health;
2. It must not be primarily custodial in nature;
3. It is ordered by a Physician for the Diagnosis or treatment of an Illness or Injury; and
4. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed, or approved by a Physician does not necessarily mean that it is "Medically Necessary." In addition, the fact that certain services are specifically excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that all other services are "Medically Necessary."

To be Medically Necessary, all of the above criteria must be met. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator's own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems appropriate.

Off-label Drug use is considered Medically Necessary when all of the following conditions are met:

a. The Drug is approved by the Food and Drug Administration (FDA);
b. The prescribed Drug use is supported by one of the following standard reference sources:

    1) Micromedex® DRUGDEX®;
    2) The American Hospital Formulary Service Drug Information;
    3) Medicare approved compendia; or
    4) Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the Drug is safe and effective for the specific condition; and

c. The Drug is otherwise Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

"Medicare"
"Medicare" shall mean the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

"Mental Health Parity Act (MHPA) of 1996 and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions"
"The Mental Health Parity Provisions" shall mean in the case of a group health plan (or health benefit coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health benefit coverage is offered in connection with such a plan); and
3. The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
4. There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health benefit coverage is offered in connection with such a plan).

"Mental or Nervous Disorder"
"Mental or Nervous Disorder" shall mean any Illness or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources. The fact that a disorder is listed in any of these sources does not mean that treatment of the disorder is covered by the Plan.

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

1. Name of an issuing State child support enforcement agency;
2. Name and mailing address (if any) of an Employee who is a Participant under the Plan or eligible for enrollment;
3. Name and mailing address of each of the Alternate Recipients (i.e., the Child or children of the Participant) or the name and address of a State or local official may be substituted \for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying Child support order.

"Network" or "In-Network"
"Network" or "In-Network" shall mean the medical Provider Network the Plan contracts with to access discounted fees for service for Participants. The Network Provider will be identified on the Participant's identification card.

Note: The term "Network" shall also refer to Preferred Providers with whom the Plan has contracted with to provide services to Participants at discounted rates, as applicable.

Network Providers do not include Hospitals, Ambulatory Surgical Centers, dialysis facilities and other facilities for Inpatient and Outpatient services. Determinations for these Providers, and Covered Expenses, will be subject to the Maximum Allowable Charge subject to the Network Provider Copayments, Coinsurance percentage and maximum limits.

"Neurobehavioral Testing"
"Neurobehavioral Testing" means an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

"Neurobehavioral Treatment"
"Neurobehavioral Treatment" means interventions that focus on behavior and the variables that control behavior.

"Neurobehavioral Rehabilitation"
"Neurobehavioral Rehabilitation" means services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

"Neurocognitive Therapy"
"Neurocognitive Therapy" means services designed to address neurological deficits in informational processing and to facilitate the development of higher-level cognitive abilities.

"Neurofeedback Therapy"
"Neurofeedback Therapy" means services that utilize operant conditioning learning procedures based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior and stabilized mood.

"Neurophysiological Testing"
"Neurophysiological Testing" means an evaluation of the functions of the nervous system.

"Neurophysiological Treatment'
"Neurophysiological Treatment" means interventions that focus on the functions of the nervous system.

"Neuropsychological Testing"
"Neuropsychological Testing" means the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

"Neuropsychological Treatment"
"Neuropsychological Treatment" means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

"No-Fault Auto Insurance"
"No-Fault Auto Insurance" is the basic reparations provision of a law or automobile insurance policy providing for payments without determining fault in connection with automobile Accidents.

"Non-Occupational Injury"
"Non-occupational Injury" shall have the meaning set forth in the definition of "Injury."

"Non-Network" or "Out-of-Network"
"Non-Network" or "Out-of-Network" is a Provider or Facility who is not under contract with the Plan for reimbursement at a negotiated rate. This means that as the patient, the Participant would be responsible for the amount charged by a Non-Network Provider that exceeds the plan's Maximum Allowable Charge. This term is used interchangeably with "Out-of-Network" and "Non-Participating."

"Nurse"
"Nurse" shall mean an individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.), and who is duly licensed by the State or regulatory agency responsible for such license in the State in which the individual performs the nursing services.

"Open Enrollment Period"
"Open Enrollment" shall mean the time period determined by the Plan Administrator. The Plan Administrator retains discretionary authority to hold open enrollment.

"Other Plan"
"Other Plan" shall include, but is not limited to:

1. Any primary payer besides the Plan;
2. Any other group health plan;
3. Any other coverage or policy covering the Participant;
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Workers' compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

"Out-of-Pocket Maximum"
"Out-of-Pocket Maximum" shall mean the total Deductible, Copayment and Coinsurance amounts for certain covered services that are a Participant's responsibility during a Plan Year. The Deductible requirements and Out-of-Pocket Maximums are listed in the Schedule of Benefits. When the Out-of-Pocket Maximum is met, eligible expenses will be covered at 100% of the allowed amount for the remainder of that Plan Year.

Each Plan Year, fulfillment of a new Out-of-Pocket Maximum is required. However, expenses incurred for services that are not covered under the Plan, charges which exceed the Maximum Allowable Charge, costs paid by the covered individual as a result of failure to comply with pre-authorization requirements, the Surgeon's copayment requirement for bariatric surgery, and charges in excess of applicable Plan maximums will not apply to fulfill this requirement.

"Outpatient"
"Outpatient" shall mean treatment including services, supplies, and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory, or x-ray facility, an Ambulatory Surgical Center, or the patient's home.

"Partial Hospitalization"
"Partial Hospitalization" shall mean medically directed intensive, or intermediate short-term mental health and Substance Abuse treatment, for a period of less than twenty-four (24) hours but more than four (4) hours in a day in a licensed or certified facility or program.

"Participant"
"Participant**"** shall mean an Employee, a Dependent, a COBRA Qualified Beneficiary, a COBRA Qualified Beneficiary's Dependent or other person meeting the eligibility requirements for coverage as specified in the Plan, and who is properly enrolled in the Plan.

"Participating Health Care Facility"
"Participating Health Care Facility" shall mean a Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

"Patient Protection and Affordable Care Act (PPACA)"
The "Patient Protection and Affordable Care Act (PPACA)" means the health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See "Affordable Care Act").

"Physician"
"Physician" shall mean a person permitted to perform services provided by this Plan who is legally entitled to perform certain medical services according to applicable and current licensure, certification, or registration ("License" or "Licensed" or "Licensure") in the state or jurisdiction where the services are rendered. The person must be acting within the scope of his or her Licensure and must hold one of the following Licenses, degrees and/or titles: a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), psychiatrist or midwife.

"Plan Appointed Claim Evaluator or "**PACE"**
"Plan Appointed Claim Evaluator or "PACE" shall mean an entity appointed by the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, with authority to make final, binding (insofar and to the same extent as a decision by the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, would be deemed to be binding), claims processing decisions in response to Final Post-Service Appeals. In instances where the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, delegates fiduciary authority to the PACE, the PACE may exercise the same level of discretionary authority as that which the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, may otherwise exercise. The PACE's fiduciary duties extend only to those determinations actually made

by the PACE. The PACE may perform other tasks on behalf of, and in consultation with, the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, but the PACE shall only be deemed to be a fiduciary when making final determinations regarding plan coverage and claims examined via Final Post-Service Appeal. The PACE shall at all times strictly abide by, and make determination in accordance with, the terms of the Plan and applicable law, in light of the facts, law, medical records, and all other information submitted to the PACE.

"Plan Year"
"Plan Year" shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

"Pre-Admission Tests"
"Pre-Admission Tests" shall mean those Diagnostic Services done prior to scheduled Surgery, provided that:

1. The tests are approved by both the Hospital and the Physician;
2. The tests are performed on an Outpatient basis prior to Hospital admission; and
3. The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the Surgery.

"Pregnancy"
"Pregnancy" shall mean carrying a Child, resulting childbirth, miscarriage, and non-elective abortion. The Plan considers Pregnancy as an Illness for the purpose of determining benefits.

"Pre-negotiated Maximum Allowable Rate"
"Pre-negotiated Maximum Allowable Rate" shall mean any negotiated agreement with a Provider which established a maximum allowable reimbursement for the Plan at a level other than the defined Maximum Allowable Charge. The Pre-negotiated Maximum Allowable Rate must be agreed upon in writing prior to the Member receiving services from the Provider. Any Provider agreeing to a Pre-negotiated Maximum Allowable Rate must agree to waive all rights to balance bill the plan or member for any amounts over and above the agreed upon Pre-negotiated Maximum Allowable Rate.

"Prescription Drug"
"Prescription Drug" means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a sickness or Injury.

"Preventive Care"
"Preventive Care" shall mean certain Preventive Care services.

To comply with the ACA, and in accordance with the recommendations and guidelines, plans shall provide In-Network coverage for:

- Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
- Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
- Comprehensive guidelines for infants, Children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
- Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found at the following websites:

https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/uspstf/search_results?searchterm=A+%26+B+
https://www.hrsa.gov/womens-guidelines-2016

For more information, Participants may contact the Plan Administrator / Employer.

"Prior Plan"
"Prior Plan" shall mean the coverage provided on a group or group type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.

"Prior to Effective Date" or "After Termination Date"
"Prior to Effective Date" or "After Termination Date" are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges Incurred Prior to the Effective Date of coverage under the Plan or after coverage is terminated, unless continuation of benefits applies.

"Privacy Standards"
"Privacy Standards" shall mean the applicable standards for the privacy of individually identifiable health information, as pursuant to HIPAA.

"Provider"
"Provider" shall mean a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical Nurse, Licensed Marriage and Family Therapist, psychological associates who work under the supervision of a Doctor in Psychology, and other practitioners or facilities defined or listed herein, or any other person, company, or institution furnishing to a Participant an item of service or supply listed as an eligible Medical Benefit.

Coverage is provided for services provided within the scope of the practitioner or supplier's license. Scope of practice refers to (1) the extent to which Providers may render health care services and the extent they may do so independently and (2) the type of diseases, ailments, and injuries a health care Provider may address. This includes the health profession's standard practices, or the assessments of the legal and physician community regarding who may perform a task and how it must be done as well as the health professional's training, skill, education, and experience. In addition, the precedent of law and the pattern of malpractice rulings define the accepted scope of practice in an area.

"Psychiatric Hospital"
"Psychiatric Hospital" shall mean an Institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the Diagnosis and treatment of mentally ill persons either by, or under the supervision of, a Physician;
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
3. It is licensed as a Psychiatric Hospital;
4. It requires that every patient be under the care of a Physician; and
5. It provides 24-hour-a-day nursing service.

The term Psychiatric Hospital does not include an Institution, or that part of an Institution, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care or educational care.

"Psychophysiological Testing"
"Psychophysiological Testing" means an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

"Psychophysiological Treatment"
"Psychophysiological Treatment" means interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

"Qualified Medical Child Support Order" or "QMCSO"
"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan.

"Qualifying Payment Amount"
"Qualifying Payment Amount" means the median of the contracted rates recognized by the Plan or recognized by all plans serviced by the Plan's Third-Party Administrator (if calculated by the Third-Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

"Recognized Amount"
"Recognized Amount" shall mean, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider's billed charge or the Qualifying Payment Amount.

"Rehabilitation"
"Rehabilitation" shall mean treatment(s) designed to facilitate the process of recovery from Injury or Illness to as normal a condition as possible.

"Rehabilitation Hospital"
"Rehabilitation Hospital" shall mean an Institution which mainly provides therapeutic and restorative services to Sick or Injured people. It is recognized as such if:

1. It carries out its stated purpose under all relevant Federal, State, and local laws;
2. It has the appropriate accreditation for its stated purpose; or
3. It is approved for its stated purpose by Medicare.

"Residential Treatment Facility"
"Residential Treatment Facility" shall mean a facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of Participants diagnosed with alcohol, drug or Substance Abuse disorders or mental illness.

"Room and Board"
"Room and Board" shall mean a Hospital's charge for:

1. Room and linen service;
2. Dietary service, including meals, special diets, and nourishment;
3. General nursing service; and
4. Other conditions of occupancy which are Medically Necessary.

"Security Standards"
"Security Standards" shall mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic Protected Health Information (PHI), as amended.

"Semi-Private Room"
The standard charge by a facility for Semi-Private room and board accommodations, or the average of such charges where the facility has more than one established level of such charges, or the lowest charge by the facility for single bedroom and board accommodations if the facility does not provide any Semi-Private accommodations.

"Service Waiting Period"
"Service Waiting Period" shall mean an interval of time during which the Employee is in the continuous, Active Employment of his or her Participating Employer.

"Skilled Nursing Facility"
"Skilled Nursing Facility" shall mean a facility that fully meets all of the following requirements:

1. It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a Physician.
3. It provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial Care, educational care, or care of Mental or Nervous Disorders.
7. It is approved and licensed by Medicare.

"Specialty Drugs"
"Specialty Drugs" for the purpose of this Plan are a narrowly defined class of extremely high-cost, biologic drugs that often require special handling, administration, and careful adherence to treatment protocols. The associated Specialty Drug list for this purpose is the Liviniti *(Southern Scripts)* Standard Specialty Drug List which contains the drugs by GPI identification.

Note: The Specialty Drug list will include both brand and generic therapies and will also include both RX Compass and non-RxCompass drugs. The RX Compass list is separate from the Liviniti (Southern Scripts) Standard Specialty Drug List.

"Substance Abuse" and/or "Substance Use Disorder"
"Substance Abuse" and/or "Substance Use Disorder" shall mean any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.

The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.

"Substance Abuse Treatment Center"
"Substance Abuse Treatment Center" shall mean an Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;
2. Accredited as such a facility with the appropriate accreditation; or
3. Licensed, certified, or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

"Surgery"
"Surgery" shall mean any of the following:

1. The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
2. The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;

3. The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
4. The induction of artificial pneumothorax and the injection of sclerosing solutions;
5. Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
6. Obstetrical delivery and dilatation and curettage; or
7. Biopsy.

"Surgical Procedure"
"Surgical Procedure" shall have the same meaning set forth in the definition of "Surgery."

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

"Uniformed Services"
"Uniformed Services" shall mean the Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

"USERRA"
"USERRA" shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ARTICLE XXIII PLAN INFORMATION

Name of Plan:	Texas Schools Health Benefits Program – Aetna Signature Copay Plan
Plan Sponsor:	Texas Schools Health Benefits Program 2175 N Glenville Dr, Richardson, TX 75082
Plan Administrator (Named Fiduciary)	Texas Schools Health Benefits Program 2175 N Glenville Dr, Richardson, TX 75082
Plan Sponsor ID No. (EIN):	85-1055440
Source of Funding:	Self-Funded
Plan Status:	Non-Grandfathered
Applicable Law:	Federal and the State of Texas
Plan Year:	September 1 through August 31
Plan Type:	Medical Prescription Drug
Third Party Administrator:	90 Degree Benefits
Mailing Address:	P.O. Box 21548 Eagan, MN 55121
Street Address:	4401 82nd Street Ste 1200 Lubbock, TX 79424 Phone: 1 (888) 803-0081 Fax: 1 (806) 698-5823
Prescription Drug Plan Administrator:	Liviniti *(Southern Scripts)* Customer Service: Toll Free: 1 (833) 439-9618 Fax: 1 (318) 214-4190 Pharmaceutical Drug look-up tool: https://member.southernscripts.net Hours of Operation: Available 7 days a week/ 24 hours a day
Specialty Drug Program Assistance	RxCompass Phone: Toll Free: 1 (833) 652-8379 Website https://myrxcompass.com/
Participating Employer(s):	"Employer" is the participating school district in the Texas Schools Health Benefits Program.

Agent for Service of Process: Texas Schools Health Benefits Program
2175 N Glenville Dr,
Richardson, TX 75082