PLAN DOCUMENT
SUMMARY PLAN DESCRIPTION

for

THE DISTRICT SCHOOL BOARD OF COLLIER COUNTY
HEALTH BENEFITS PLAN

This booklet describes the Plan Benefits
in effect as of March 1, 2020

The Plan has been established for the benefit of
eligible Employees, Retirees and their Dependents of:

THE DISTRICT SCHOOL BOARD OF COLLIER COUNTY

Claims Processed By:

ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC.
PO Box 3018
Missoula, MT 59806-3018

Toll-Free Number: (855) 333-1012

COVER/SIGNATURE PAGE

Effective March 1, 2020, The District School Board of Collier County reinstates its self-funded Health Care Plan for the benefit of eligible Employees, Retirees and their eligible Dependents entitled, **THE DISTRICT SCHOOL BOARD OF COLLIER COUNTY HEALTH BENEFITS PLAN** (the "Plan").

The purpose of this Plan is to provide reimbursement for Expenses Incurred for covered services, treatment or supplies as a result of Medically Necessary treatment for Illness or Injury of the Employer's eligible Employees, Retirees and their eligible Dependents. The Employer, in conjunction with any required contributions by its Employees, agrees to make payments to the Plan's Trust in order for payments to be made for covered services, treatments or supplies as provided by this Plan.

The Employer has caused this instrument to be executed as of the day first mentioned above.

THE DISTRICT SCHOOL BOARD OF COLLIER COUNTY

BY: Valerie Wenrich

TITLE: Executive Director of HR

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INTRODUCTION

Effective March 1, 2020, The District School Board of Collier County, hereinafter referred to as the "Employer", restates the benefits, rights and privileges which will pertain to participating Employees, referred to as "Participants", "Retirees" and the eligible Dependents of such Participants and Retirees, as defined, and which benefits are provided through a fund established by the Employer and referred to as the "Plan". This booklet describes the Plan in effect as of March 1, 2020.

Coverage provided under this Plan for Employees and their Dependents will be in accordance with the Eligibility, Effective Date, Qualified Medical Child Support Order, Termination, Family and Medical Leave Act and other applicable provisions as stated in this Plan.

The District School Board of Collier County (the Plan Sponsor) has retained the services of an independent Third Party Administrator, experienced in claims processing, to handle health claims. The Third Party Administrator for the Plan is:

Allegiance Benefit Plan Management, Inc.
P.O. Box 3018
Missoula, MT 59806-3018

Please read this booklet carefully before incurring any medical expenses. For specific questions regarding coverage or benefits, please refer to the Plan Document which is available for review in the Benefits Office, at the office of the Third Party Administrator or call or write to Allegiance Benefit Plan Management, Inc. regarding any detailed questions concerning the Plan.

This Plan is not intended to, and cannot be used as workers' compensation coverage for any Employee or any covered Dependent of an Employee. Therefore, this Plan generally excludes claims related to any activity engaged in for wage or profit including, but not limited to, farming, ranching, part-time and seasonal activities. See Plan Exclusions for specific information.

The information contained in this Plan Document/Summary Plan Description is only a general statement regarding FMLA, COBRA, USERRA, and QMCSO's. It is not intended to be and should not be relied upon as complete legal information about those subjects.

IN-NETWORK BENEFIT

This Plan provides benefits through a group of contracted providers (In-Network Providers). An In-Network Provider means using a Provider who is part of the group of contracted providers. Using In-Network Providers offers cost-savings advantages because a Covered Person pays only a percentage of the scheduled fee for services provided. The District School Board of Collier County has contracted with Community Health Partners (CHP) to provide In-Network Services for Covered Persons.

Out-of-Network Provider means a provider who is not an In-Network Provider. A Covered Person who goes Out-of-Network will pay more and his or her share of the cost may not apply to the Out-of-Pocket Maximum.

For a list of providers in the CHP Network, contact (239) 659-7770 or (888) 594-9008. To determine if a Physician or health care provider qualifies as an eligible In-Network Provider under this Plan, please consult Allegiance's website at www.askallegiance.com/dsbcc to access links for directories of participating providers.

OUT-OF-NETWORK BENEFIT EXCEPTION

When a covered service is rendered by an Out-of-Network Provider, charges will be paid as if the service were rendered by an In-Network Provider only under one of the following circumstances:

1. Charges for an Emergency, as defined by this Plan, limited to only those Emergency medical procedures necessary to treat and stabilize an eligible Injury or Illness and then only to the extent that the same are necessary in order for the Covered Person to be transported, at the earliest medically appropriate time to an In-Network Hospital, clinic or other facility, or discharged; or

2. Charges which are incurred as a result of and related to confinement in or use of an In-Network Hospital, clinic or other facility only for Out-of-Network services and providers over whom or which the Covered Person does not have any choice in or ability to select. The Plan UCR limitations will not apply to this exception.

PATHWAYS TO ENHANCED HEALTH INCENTIVE

Pathways is a voluntary incentive-based wellness program which allows a covered Employee to qualify for lower out-of-pocket costs (incentives) by participating in a variety of research-based wellness activities. These activities are designed to improve health awareness, support and maintain good health and address chronic disease or serious medical conditions. Covered Employees who choose not to participate in wellness activities will remain in the Basic Pathway for the subsequent Plan Year. Covered Dependents will be enrolled in the same Pathway as the Employee. The three Pathways are:

1. **Basic Pathway** - no incentives
2. **Custom Pathway** - partial incentives
3. **Enhanced Pathway** - full incentives

BASIC PATHWAY (no incentives)
SCHEDULE OF MEDICAL BENEFITS
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND THE USUAL, CUSTOMARY AND REASONABLE LIMITS OF THE PLAN

THE BENEFIT PERIOD IS A CALENDAR YEAR

MEDICAL BENEFIT COST SHARING PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE		
Per Covered Person per Benefit Period	$3,000	$6,000
Per Family per Benefit Period	$6,000	$12,000
In-Network charges apply only toward the In-Network Deductible and Out-of-Network charges apply only toward the Out-of-Network Deductible.		
The Deductible applies to all Eligible Expenses, unless specifically stated otherwise. An individual Covered Person cannot receive credit toward the Family Deductible for more than the individual Annual Deductible.		
BENEFIT PERCENTAGE (The Plan Pays)		
Before satisfaction of Out-of-Pocket Maximum	60%	50%
After satisfaction of Out-of-Pocket Maximum	100%	100%
The Benefit Percentage applies to all Eligible Expenses, unless specifically stated otherwise. Eligible Expenses will be paid by the Plan according to the applicable Benefit Percentage.		
OUT-OF-POCKET MAXIMUM		
Per Covered Person per Benefit Period	$4,700	$16,000
Per Family per Benefit Period	$9,400	$32,000
The Out-of-Pocket Maximum includes amounts applied towards the Deductible. After the Out-of-Pocket Maximum is satisfied, no further Deductible is required for the remainder of the Benefit Period.		
In-Network charges apply only toward the In-Network Out-of-Pocket Maximum and Out-of-Network charges apply only toward the Out-of-Network Out-of-Pocket Maximum.		
The Out-of-Pocket Maximum applies to all Eligible Expenses, unless specifically stated otherwise, including amounts applied toward the Deductible and amounts in excess of the Benefit Percentage. After Deductible and Out-of-Pocket Maximum is satisfied, Eligible Expenses are Payable at 100%.		
MAXIMUM ANNUAL OR LIFETIME BENEFIT FOR ALL CAUSES	Unlimited	

MEDICAL BENEFITS/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
Acupuncture/Naturopathy	60% after Deductible	50% after Deductible
Benefit Limits: $500 Combined Benefit Maximum Per Benefit Period. **Benefit limits are for services received from Network and Non-Network Providers.**		

MEDICAL BENEFITS/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT IN-NETWORK	OUT-OF-NETWORK
Ambulance Service	60% after Deductible	50% after Deductible
Air Ambulance is subject to the Maximum Eligible Expense limit which means the maximum amount considered for payment by this Plan for Air Ambulance Services. The following criteria will apply to determination of the Maximum Eligible Expense: 1. A contracted amount as established by a preferred provider or other discounting contract; 2. 250% of the allowable charge established by application of the Medicare Ambulance Fee Schedule; or 3. The billed charge if less than 1 or 2 above.		
Chiropractic Services	60% after Deductible	50% after Deductible
Emergency Room Services for Emergency use only	60% after In-Network Deductible	
Charges for Emergency Room Services for non-emergency use, including the facility and professional fees are not covered.		
Emotional Wellness Program through CHP	100%, Deductible Waived	No Coverage
Hearing Aid and Exam Benefit*	60% after Deductible	50% after Deductible
Benefit Limits: $1,000 Maximum Benefit Per Benefit Period. **Benefit limits are for services received from Network and Non-Network Providers.** *Includes all charges - See Medical Benefits		
Home Health Care	60% after Deductible	50% after Deductible
Hospice Care, including Bereavement Counseling	100%, Deductible Waived	100%, Deductible Waived
Hospital Services		
Inpatient	60% after Deductible	50% after Deductible
Outpatient	60% after Deductible	50% after Deductible
Pre-certification is required for all Inpatient Admissions. The Benefit Percentage will be reduced to 50% if the procedures for pre-certifying are not followed. This penalty does not apply to the Out-of-Pocket Maximum.		
MDLive Consultations	100% after $20 Copayment, Deductible Waived	No Coverage
For telephone consultations through MDLive, please consult www.mdlive.com/allegiance or call (877) 753-7992. Telemedicine other than MDLive consultations are not covered, except for Telemedicine provided under the Emotional Wellness Program through CHP as stated in this Schedule of Medical Benefits.		
Mental Illness and Substance Abuse Treatment		
Inpatient	60% after Deductible	50% after Deductible
Outpatient	60% after Deductible	50% after Deductible
Pre-certification is required for all Inpatient Admissions. See Notification Provision section for further details.		

MEDICAL BENEFITS/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
Organ and Tissue Transplant Services and Travel expenses	60% after Deductible	50% after Deductible

Organ and Tissue Transplant Benefit Limits:

Maximum Benefit for each Procedure:

Allogenic Stem Cell (related)	$250,000
Allogenic Stem Cell (unrelated)	$340,000
Autologous Stem Cell	$140,000
Stem Cell Other	$230,000
Heart	$275,000
Heart Lung	$345,000
Intestine	$485,000
Kidney	$95,000
Kidney Pancreas	$160,000
Liver	$220,000
Lung	$275,000
Pancreas	$140,000
Solid Other	$440,000
Other Eligible Transplant or Replacement Procedure	$75,000

Benefit limits are for services received from Non-Network Providers.

Benefit limits apply to all expenses in connection with any eligible organ or tissue transplant procedure as stated in Medical Benefits section under Organ and Tissue Transplant Services.

Services subject to the benefit limits include, but are not limited to: evaluation; pre-transplant, transplant and post-transplant care (not including Outpatient immunosuppressant drugs); organ donor search, procurement and retrieval; complications related to the procedure and follow-up care for services received during the 12-month period from the date of transplant. Charges for services incurred after such 12-month period are eligible under the Medical Benefits of this Plan and do not accrue toward the Transplant benefit limits.

Amounts exceeding the maximum case rate at contracted Center of Excellence (also known as outliers) will be eligible for reimbursement under Medical Benefits. Excess charges at non-contracted facilities will not be eligible for reimbursement.

Travel Benefit Limits: Travel expenses are payable at 100% up to $10,000 per transplant, limited to the following:

- Coach airfare
- Mileage if driving reimbursed at IRS standard mileage rate
- Meals and lodging limited to $200 per day per person

Outpatient Physical, Occupational and Speech Therapy	60% after Deductible	50% after Deductible
Outpatient Renal Dialysis Benefit	100%, Deductible Waived	100%, Deductible Waived

Out-of-Network Medical Service/Supplies: Maximum Benefit 125% of Medicare Allowable
ESRD Related Drugs: Maximum Benefit of 125% of the Average Sales Price (ASP)

Pain Management	60% after Deductible	50% after Deductible

Benefit Limits: Epidurals are limited to 6 per Benefit Period. **Benefit limits are for services received from Network and Non-Network Providers.**

Pre-certification is required for Pain Management.

MEDICAL BENEFITS/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
Physician Services	60% after Deductible	50% after Deductible
Prenatal/Parental Education	100%, Deductible Waived	No Coverage
Preventive Care (See Medical Benefits Section)	100%, Deductible Waived	No coverage
Residential Treatment Facility	60% after Deductible	50% after Deductible
Pre-certification is required for all Inpatient Admissions. See Notification Provision section for further details.		
Routine Well-Baby Newborn Inpatient Nursery/Physician Care	60%, Deductible Waived	50% after Deductible
This benefit applies only to charges incurred prior to discharge for a Newborn who is discharged within 48 hours following the mother's normal vaginal delivery, or less than 96 hours following the mother's cesarean section. Otherwise, the Newborn's charges are payable under the normal Medical Benefits of this Plan.		
Skilled Nursing Facility	60% after Deductible	50% after Deductible
Pre-certification is required for all Inpatient Admissions. See Notification Provision section for further details.		
Urgent Care Facility, Urgent Care Center or Convenience Walk-in-clinic	60% after Deductible	50% after Deductible
Weight Loss Surgery (only if pre-approved. See Weight Loss Surgery Program)	50% after Deductible	No coverage
The Out-of-Pocket Maximum does not apply to this benefit and the Benefit Percentage remains at 50% even after the Out-of-Pocket Maximum has been satisfied. Eligible benefits include surgery, surgeon, anesthesia and facility charges related directly to the weight loss surgery.		

CUSTOM PATHWAY (partial incentives)
SCHEDULE OF MEDICAL BENEFITS
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND THE USUAL, CUSTOMARY AND REASONABLE LIMITS OF THE PLAN

THE BENEFIT PERIOD IS A CALENDAR YEAR

MEDICAL BENEFIT COST SHARING PROVISIONS	**IN-NETWORK**	**OUT-OF-NETWORK**
DEDUCTIBLE		
Per Covered Person per Benefit Period	$1,000	$1,300
Per Family per Benefit Period	$2,000	$2,600
In-Network charges apply only toward the In-Network Deductible and Out-of-Network charges apply only toward the Out-of-Network Deductible. Copayments do not apply towards the Deductible. The Deductible applies to all Eligible Expenses, unless specifically stated otherwise. An individual Covered Person cannot receive credit toward the Family Deductible for more than the individual Annual Deductible.		
BENEFIT PERCENTAGE (The Plan Pays)		
Before satisfaction of Out-of-Pocket Maximum	70%	55%
After satisfaction of Out-of-Pocket Maximum	100%	100%
The Benefit Percentage applies to all Eligible Expenses, unless specifically stated otherwise. Eligible Expenses will be paid by the Plan according to the applicable Benefit Percentage.		
OUT-OF-POCKET MAXIMUM		
Per Covered Person per Benefit Period	$4,450	$8,500
Per Family per Benefit Period	$8,900	$17,000
The Out-of-Pocket Maximum includes amounts applied towards the Deductible and any applicable Medical Copayments. After the Out-of-Pocket Maximum is satisfied, no further Deductible is required and Copayments are waived for the remainder of the Benefit Period. In-Network charges apply only toward the In-Network Out-of-Pocket Maximum and Out-of-Network charges apply only toward the Out-of-Network Out-of-Pocket Maximum. The Out-of-Pocket Maximum applies to all Eligible Expenses, unless specifically stated otherwise, including amounts applied toward the Deductible, amounts in excess of the Benefit Percentage and Copayment amounts. After Deductible and Out-of-Pocket Maximum is satisfied, Copayments are waived and Eligible Expenses are Payable at 100% for the remainder of the Benefit Period.		

MEDICAL BENEFIT COST SHARING PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
OFFICE VISITS		
Primary Care Physician (PCP)	$50 Copayment per Visit	55% Benefit Percentage
Specialty Care Physician (SCP)	$75 Copayment per Visit	55% Benefit Percentage
Copayment is a flat dollar amount paid for medical services by a Covered Person per office visit. Services for which a Copayment applies are covered at 100% after the Covered Person pays the Copayment. The Copayment applies to all services performed in the office in conjunction or associated with the office visit charge, not to exceed $500 per visit. Charges exceeding $500 will be subject to the Deductible and Benefit Percentage. If more than one Physician is seen in the same clinic on the same day, only one Copayment will apply.		
URGENT CARE FACILITY, URGENT CARE CENTER OR CONVENIENCE WALK-IN-CLINIC		
Primary Care Physician (PCP)	$50 Copayment per Visit	55% Benefit Percentage
Specialty Care Physician (SCP)	$75 Copayment per Visit	55% Benefit Percentage
Copayment is a flat dollar amount paid for medical services by a Covered Person per office visit. Services for which a Copayment applies are covered at 100% after the Covered Person pays the Copayment. The Copayment applies to all services performed in the office in conjunction or associated with the charge for the urgent care visit, not to exceed $500 per visit. Charges exceeding $500 will be subject to the Deductible and Benefit Percentage. If more than one Physician is seen in the same clinic on the same day, only one Copayment will apply.		
MAXIMUM ANNUAL OR LIFETIME BENEFIT FOR ALL CAUSES	Unlimited	

MEDICAL BENEFITS/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
Acupuncture/Naturopathy	70% after Deductible	55% after Deductible
Benefit Limits: $500 Combined Benefit Maximum Per Benefit Period. **Benefit limits are for services received from Network and Non-Network Providers.**		
Ambulance Service	70% after Deductible	55% after Deductible
Air Ambulance is subject to the Maximum Eligible Expense limit which means the maximum amount considered for payment by this Plan for Air Ambulance Services. The following criteria will apply to determination of the Maximum Eligible Expense: 1. A contracted amount as established by a preferred provider or other discounting contract; 2. 250% of the allowable charge established by application of the Medicare Ambulance Fee Schedule; or 3. The billed charge if less than 1 or 2 above.		
Chiropractic Services	100% after SCP Copayment up to $500, then 70% after Deductible	55% after Deductible

MEDICAL BENEFITS/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT IN-NETWORK	OUT-OF-NETWORK
Emergency Room Services for Emergency use only	70% after In-Network Deductible	
Charges for Emergency Room Services for non-emergency use, including the facility and professional fees are not covered.		
Emotional Wellness Program through CHP	100%, Deductible Waived	No Coverage
Hearing Aid and Exam Benefit*	70% after Deductible	55% after Deductible
Benefit Limits: $1,000 Maximum Benefit Per Benefit Period. **Benefit limits are for services received from Network and Non-Network Providers.**		
*Includes all charges - See Medical Benefits		
Home Health Care	70% after Deductible	55% after Deductible
Hospice Care, including Bereavement Counseling	100%, Deductible Waived	100%, Deductible Waived
Hospital Services		
Inpatient	70% after Deductible	55% after Deductible
Outpatient	70% after Deductible	55% after Deductible
Pre-certification is required for all Inpatient Admissions. The Benefit Percentage will be reduced to 50% if the procedures for pre-certifying are not followed. This penalty does not apply to the Out-of-Pocket Maximum.		
MDLive Consultations	100% after $15 Copayment, Deductible Waived	No Coverage
For telephone consultations through MDLive, please consult www.mdlive.com/allegiance or call (877) 753-7992. Telemedicine other than MDLive consultations are not covered, except for Telemedicine provided under the Emotional Wellness Program through CHP as stated in this Schedule of Medical Benefits.		
Mental Illness and Substance Abuse Treatment		
Inpatient	70% after Deductible	55% after Deductible
Outpatient	70% after Deductible	55% after Deductible
Office Visit	100% after $50 Copayment up to $500, then 70% after Deductible	55% after Deductible
Pre-certification is required for all Inpatient Admissions. The Benefit Percentage will be reduced to 50% if the procedures for pre-certifying are not followed. This penalty does not apply to the Out-of-Pocket Maximum.		

MEDICAL BENEFITS/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
Organ and Tissue Transplant Services and Travel expenses	70% after Deductible	55% after Deductible

Organ and Tissue Transplant Benefit Limits:

Maximum Benefit for each Procedure:

Allogenic Stem Cell (related)	$250,000
Allogenic Stem Cell (unrelated)	$340,000
Autologous Stem Cell	$140,000
Stem Cell Other	$230,000
Heart	$275,000
Heart Lung	$345,000
Intestine	$485,000
Kidney	$95,000
Kidney Pancreas	$160,000
Liver	$220,000
Lung	$275,000
Pancreas	$140,000
Solid Other	$440,000
Other Eligible Transplant or Replacement Procedure	$75,000

Benefit limits are for services received from Non-Network Providers.

Benefit limits apply to all expenses in connection with any eligible organ or tissue transplant procedure as stated in Medical Benefits section under Organ and Tissue Transplant Services.

Services subject to the benefit limits include, but are not limited to: evaluation; pre-transplant, transplant and post-transplant care (not including Outpatient immunosuppressant drugs); organ donor search, procurement and retrieval; complications related to the procedure and follow-up care for services received during the 12-month period from the date of transplant. Charges for services incurred after such 12-month period are eligible under the Medical Benefits of this Plan and do not accrue toward the Transplant benefit limits.

Amounts exceeding the maximum case rate at contracted Center of Excellence (also known as outliers) will be eligible for reimbursement under Medical Benefits. Excess charges at non-contracted facilities will not be eligible for reimbursement.

Travel Benefit Limits: Travel expenses are payable at 100% up to $10,000 per transplant, limited to the following:

- Coach airfare
- Mileage if driving reimbursed at IRS standard mileage rate
- Meals and lodging limited to $200 per day per person

Travel expenses are payable at 100% up to $10,000 per transplant, limited to the following:

- Coach airfare
- Mileage if driving reimbursed at IRS standard mileage rate
- Meals and lodging limited to $200 per day per person

Outpatient Physical, Occupational and Speech Therapy	70% after Deductible	55% after Deductible

MEDICAL BENEFITS/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT IN-NETWORK	OUT-OF-NETWORK
Outpatient Renal Dialysis Benefit	100%, Deductible Waived	100%, Deductible Waived
Out-of-Network Medical Service/Supplies: Maximum Benefit 125% of Medicare Allowable ESRD Related Drugs: Maximum Benefit of 125% of the Average Sales Price (ASP)		
Pain Management	70% after Deductible	55% after Deductible
Benefit Limits: Epidurals are limited to 6 per Benefit Period. **Benefit limits are for services received from Network and Non-Network Providers.** Pre-certification is required for Pain Management.		
Physician Services Inpatient/Outpatient Services, except for in-office services	70% after Deductible	55% after Deductible
Office Visits	100% after applicable Copayment up to $500, then 70% after Deductible	55% after Deductible
Prenatal/Parental Education	100%, Deductible Waived	No Coverage
Preventive Care (See Medical Benefits Section)	100%, Deductible Waived	No Coverage
Residential Treatment Facility	70% after Deductible	55% after Deductible
Pre-certification is required for all Inpatient Admissions. The Benefit Percentage will be reduced to 50% if the procedures for pre-certifying are not followed. This penalty does not apply to the Out-of-Pocket Maximum.		
Routine Well-Baby Newborn Inpatient Nursery/Physician Care	70%, Deductible Waived	55% after Deductible
This benefit applies only to charges incurred prior to discharge for a Newborn who is discharged within 48 hours following the mother's normal vaginal delivery, or less than 96 hours following the mother's cesarean section. Otherwise, the Newborn's charges are payable under the normal Medical Benefits of this Plan.		
Skilled Nursing Facility	70% after Deductible	55% after Deductible
Pre-certification is required for all Inpatient Admissions. The Benefit Percentage will be reduced to 50% if the procedures for pre-certifying are not followed. This penalty does not apply to the Out-of-Pocket Maximum.		
Urgent Care Facility, Urgent Care Center or Convenience Walk-in-clinic	100% after applicable Copayment up to $500, then 70% after Deductible	55% after Deductible
Weight Loss Surgery (only if pre-approved. See Weight Loss Surgery Program)	50% after Deductible	No coverage
The Out-of-Pocket Maximum does not apply to this benefit and the Benefit Percentage remains at 50% even after the Out-of-Pocket Maximum has been satisfied. Eligible benefits include surgery, surgeon, anesthesia and facility charges related directly to the weight loss surgery.		

ENHANCED PATHWAY (full incentives)
SCHEDULE OF MEDICAL BENEFITS
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND THE USUAL, CUSTOMARY AND REASONABLE LIMITS OF THE PLAN

THE BENEFIT PERIOD IS A CALENDAR YEAR

MEDICAL BENEFIT COST SHARING PROVISIONS	**IN-NETWORK**	**OUT-OF-NETWORK**
DEDUCTIBLE		
Per Covered Person per Benefit Period	$400	$800
Per Family per Benefit Period	$800	$1,600
In-Network charges apply only toward the In-Network Deductible and Out-of-Network charges apply only toward the Out-of-Network Deductible. Copayments do not apply towards the Deductible.		
The Deductible applies to all Eligible Expenses, unless specifically stated otherwise. An individual Covered Person cannot receive credit toward the Family Deductible for more than the individual Annual Deductible.		
BENEFIT PERCENTAGE (The Plan Pays)		
Before satisfaction of Out-of-Pocket Maximum	80%	60%
After satisfaction of Out-of-Pocket Maximum	100%	100%
The Benefit Percentage applies to all Eligible Expenses, unless specifically stated otherwise. Eligible Expenses will be paid by the Plan according to the applicable Benefit Percentage.		
OUT-OF-POCKET MAXIMUM		
Per Covered Person per Benefit Period	$2,400	$4,800
Per Family per Benefit Period	$4,800	$9,600
The Out-of-Pocket Maximum includes amounts applied towards the Deductible and any applicable Medical Copayments. After the Out-of-Pocket Maximum is satisfied, no further Deductible is required and Copayments are waived for the remainder of the Benefit Period.		
In-Network charges apply only toward the In-Network Out-of-Pocket Maximum and Out-of-Network charges apply only toward the Out-of-Network Out-of-Pocket Maximum.		
The Out-of-Pocket Maximum applies to all Eligible Expenses, unless specifically stated otherwise, including amounts applied toward the Deductible, amounts in excess of the Benefit Percentage and Copayments amounts. After the Deductible and Out-of-Pocket Maximum is satisfied, Copayments are waived and Eligible Expenses are Payable at 100% for the remainder of the Benefit Period.		

MEDICAL BENEFIT COST SHARING PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
OFFICE VISITS		
Primary Care Physician (PCP)	$30 Copayment per Visit	60% Benefit Percentage
Specialty Care Physician (SCP)	$50 Copayment per Visit	60% Benefit Percentage
Copayment is a flat dollar amount paid for medical services by a Covered Person per office visit. Services for which a Copayment applies are covered at 100% after the Covered Person pays the Copayment. The Copayment applies to all services performed in the office in conjunction or associated with the office visit charge, not to exceed $500 per visit. Charges exceeding $500 will be subject to the Deductible and Benefit Percentage. If more than one Physician is seen in the same clinic on the same day, only one Copayment will apply.		
URGENT CARE FACILITY, URGENT CARE CENTER OR CONVENIENCE WALK-IN-CLINIC		
Primary Care Physician (PCP)	$30 Copayment per Visit	60% Benefit Percentage
Specialty Care Physician (SCP)	$50 Copayment per Visit	60% Benefit Percentage
Copayment is a flat dollar amount paid for medical services by a Covered Person per office visit. Services for which a Copayment applies are covered at 100% after the Covered Person pays the Copayment. The Copayment applies to all services performed in the office in conjunction or associated with the charge for the urgent care visit, not to exceed $500 per visit. Charges exceeding $500 will be subject to the Deductible and Benefit Percentage. If more than one Physician is seen in the same clinic on the same day, only one Copayment will apply.		
MAXIMUM ANNUAL OR LIFETIME BENEFIT FOR ALL CAUSES	Unlimited	

MEDICAL BENEFITS/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
Acupuncture/Naturopathy	80% after Deductible	60% after Deductible
Benefit Limits: $500 Combined Benefit Maximum Per Benefit Period. **Benefit limits are for services received from Network and Non-Network Providers.**		
Ambulance Service	80% after Deductible	60% after Deductible
Air Ambulance is subject to the Maximum Eligible Expense limit which means the maximum amount considered for payment by this Plan for Air Ambulance Services. The following criteria will apply to determination of the Maximum Eligible Expense: 1. A contracted amount as established by a preferred provider or other discounting contract; 2. 250% of the allowable charge established by application of the Medicare Ambulance Fee Schedule; or 3. The billed charge if less than 1 or 2 above.		
Chiropractic Services	100% after SCP Copayment up to $500, then 80% after Deductible	60% after Deductible

MEDICAL BENEFITS/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT IN-NETWORK	OUT-OF-NETWORK
Emergency Room Services for Emergency use only	80% after In-Network Deductible	
Charges for Emergency Room Services for non-emergency use, including the facility and professional fees are not covered.		
Emotional Wellness Program through CHP	100%, Deductible Waived	No Coverage
Hearing Aid and Exam Benefit*	80% after Deductible	60% after Deductible
Benefit Limits: $1,000 Maximum Benefit Per Benefit Period. **Benefit limits are for services received from Network and Non-Network Providers.**		
*Includes all charges - See Medical Benefits		
Home Health Care	80% after Deductible	60% after Deductible
Hospice Care, including Bereavement Counseling	100%, Deductible Waived	100%, Deductible Waived
Hospital Services		
Inpatient	80% after Deductible	60% after Deductible
Outpatient	80% after Deductible	60% after Deductible
Pre-certification is required for all Inpatient Admissions. The Benefit Percentage will be reduced to 50% if the procedures for pre-certifying are not followed. This penalty does not apply to the Out-of-Pocket Maximum.		
MDLive Consultations	100% after $10 Copayment, Deductible Waived	No Coverage
For telephone consultations through MDLive, please consult www.mdlive.com/allegiance or call (877) 753-7992. Telemedicine other than MDLive consultations are not covered, except for Telemedicine provided under the Emotional Wellness Program through CHP as stated in this Schedule of Medical Benefits.		
Mental Illness and Substance Abuse Treatment		
Inpatient	80% after Deductible	60% after Deductible
Outpatient	80% after Deductible	60% after Deductible
Office Visit	100% after $30 Copayment up to $500, then 80% after Deductible	60% after Deductible
Pre-certification is required for all Inpatient Admissions. The Benefit Percentage will be reduced to 50% if the procedures for pre-certifying are not followed. This penalty does not apply to the Out-of-Pocket Maximum.		

MEDICAL BENEFITS/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
Organ and Tissue Transplant Services and Travel expenses	80% after Deductible	60% after Deductible

Organ and Tissue Transplant Benefit Limits:

Maximum Benefit for each Procedure:

- Allogenic Stem Cell (related) $250,000
- Allogenic Stem Cell (unrelated) $340,000
- Autologous Stem Cell $140,000
- Stem Cell Other $230,000
- Heart $275,000
- Heart Lung $345,000
- Intestine $485,000
- Kidney $95,000
- Kidney Pancreas $160,000
- Liver $220,000
- Lung $275,000
- Pancreas $140,000
- Solid Other $440,000
- Other Eligible Transplant or Replacement Procedure $75,000

Benefit limits are for services received from Non-Network Providers.

Benefit limits apply to all expenses in connection with any eligible organ or tissue transplant procedure as stated in Medical Benefits section under Organ and Tissue Transplant Services.

Services subject to the benefit limits include, but are not limited to: evaluation; pre-transplant, transplant and post-transplant care (not including Outpatient immunosuppressant drugs); organ donor search, procurement and retrieval; complications related to the procedure and follow-up care for services received during the 12-month period from the date of transplant. Charges for services incurred after such 12-month period are eligible under the Medical Benefits of this Plan and do not accrue toward the Transplant benefit limits.

Amounts exceeding the maximum case rate at contracted Center of Excellence (also known as outliers) will be eligible for reimbursement under Medical Benefits. Excess charges at non-contracted facilities will not be eligible for reimbursement.

Travel Benefit Limits: Travel expenses are payable at 100% up to $10,000 per transplant, limited to the following:

- Coach airfare
- Mileage if driving reimbursed at IRS standard mileage rate
- Meals and lodging limited to $200 per day per person

Travel expenses are payable at 100% up to $10,000 per transplant, limited to the following:

- Coach airfare
- Mileage if driving reimbursed at IRS standard mileage rate
- Meals and lodging limited to $200 per day per person

Outpatient Physical, Occupational and Speech Therapy	80% after Deductible	60% after Deductible

MEDICAL BENEFITS/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
Outpatient Renal Dialysis Benefit	100%, Deductible Waived	100%, Deductible Waived
Out-of-Network Medical Service/Supplies: Maximum Benefit 125% of Medicare Allowable ESRD Related Drugs: Maximum Benefit of 125% of the Average Sales Price (ASP)		
Pain Management	80% after Deductible	60% after Deductible
Benefit Limits: Epidurals are limited to 6 per Benefit Period. **Benefit limits are for services received from Network and Non-Network Providers.** Pre-certification is required for Pain Management.		
Physician Services Inpatient/Outpatient Services, except for in-office services	80% after Deductible	60% after Deductible
Office Visits	100% after applicable Copayment up to $500, then 80% after Deductible	60% after Deductible
Prenatal/Parental Education	100%, Deductible Waived	No Coverage
Preventive Care (See Medical Benefits Section)	100%, Deductible Waived	No Coverage
Residential Treatment Facility	80% after Deductible	60% after Deductible
Pre-certification is required for all Inpatient Admissions. The Benefit Percentage will be reduced to 50% if the procedures for pre-certifying are not followed. This penalty does not apply to the Out-of-Pocket Maximum.		
Routine Well-Baby Newborn Inpatient Nursery/Physician Care	80%, Deductible Waived	60% after Deductible
This benefit applies only to charges incurred prior to discharge for a Newborn who is discharged within 48 hours following the mother's normal vaginal delivery, or less than 96 hours following the mother's cesarean section. Otherwise, the Newborn's charges are payable under the normal Medical Benefits of this Plan.		
Skilled Nursing Facility	80% after Deductible	60% after Deductible
Pre-certification is required for all Inpatient Admissions. The Benefit Percentage will be reduced to 50% if the procedures for pre-certifying are not followed. This penalty does not apply to the Out-of-Pocket Maximum.		
Urgent Care Facility, Urgent Care Center or Convenience Walk-in-clinic	100% after applicable Copayment up to $500, then 80% after Deductible	60% after Deductible
Weight Loss Surgery (only if pre-approved. See Weight Loss Surgery Program)	50% after Deductible	No coverage
The Out-of-Pocket Maximum does not apply to this benefit and the Benefit Percentage remains at 50% even after the Out-of-Pocket Maximum has been satisfied. Eligible benefits include surgery, surgeon, anesthesia and facility charges related directly to the weight loss surgery.		

PHARMACY BENEFIT

Prescription drug charges are payable only through the Plan's Pharmacy Benefit Manager (PBM) program, which program is sponsored in conjunction with and is an integral part of this Plan. Coinsurance does not serve to satisfy the Medical Benefits Annual Deductible or Out-of-Pocket Maximum. However, Pharmacy Deductible and Coinsurance does apply toward the applicable Pharmacy Benefit Out-of-Pocket Maximum. The PBM will provide separate information for details regarding Network Pharmacies, Prescription Drugs and Specialty Drugs upon enrollment for coverage under this Plan.

Member Choice (DAW2): the Physician does not prescribe "Dispense as Written" (DAW), and there is a Tier 1 alternative for the prescription drug, and the Covered Person chooses a Tier 2 drug instead, the Covered Person must pay the difference in cost between the Tier 1 and Tier 2 medication plus the applicable Tier 2 Coinsurance amount.

There is no Coordination of Benefits for Pharmacy Benefits.

Expenses for injectables that are not covered under the Pharmacy Benefit and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under the Medical Benefits of this Plan subject to any applicable Cost Sharing provision as well as any coverage limitations and exclusions applicable to the Medical Benefits portion of the Plan. Please refer to the Medical Benefits, Medical Benefits Exclusions and General Plan Exclusions and Limitations sections of this Plan.

NOTE: Coverage, limitations and exclusions for Prescription Drugs will be determined through the Plan's Pharmacy Benefit Manager program and will not be subject to any limitations and exclusions under the Medical Benefits of the Plan (except for injectables that are not covered under the Pharmacy Benefit). For a complete listing of Prescription Drugs available under the Pharmacy Benefit, as well as any exclusions or limitations that may apply, please contact the Pharmacy Benefit Manager shown on the back of the Employee's Identification Card.

Specialty drugs are high cost drugs used to treat complex and chronic conditions, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia and Multiple Sclerosis. Self administered specialty drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Pharmacy Benefit Manager.

Specialty drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Pharmacy Benefit.

COST SHARING PROVISIONS - BASIC PATHWAY (no incentives)

Pharmacy Deductible

Per Covered Person per Benefit Period	$400

Pharmacy Out-of-Pocket Maximum

Per Covered Person per Benefit Period	$2,150
Per Family per Benefit Period	$4,300

The Deductible and Coinsurance are included when determining the Out-of-Pocket Maximum. Pharmacy Coinsurance is waived after satisfaction of the Pharmacy Out-of-Pocket Maximum.

The Deductible and Coinsurance are waived and the following are payable at 100%:

1. Prescribed Tier 1 contraceptives or Tier 2 if Tier 1 is unavailable;
2. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider; and
3. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/;
4. Oral Chemotherapy (fluoride treatment);
5. Navitus Complete Vaccine List.

Coinsurance after Deductible met			
Drug Type	**Retail - PBM Network**	**Member Submit***	**Mail Order**
Tier 1	40%	40%	40%
Tier 2	40%	40%	40%
Tier 3	60%	60%	60%

*For Member Submit prescriptions, the PBM will reimburse the contract cost of the prescription drug, less the applicable Coinsurance per Prescription. Contract cost is the PBM's discounted cost of the prescription drug. Reimbursement will not exceed what the PBM would have reimbursed for a Network Prescription.

COST SHARING PROVISIONS - CUSTOM PATHWAY (partial incentives)

Pharmacy Deductible

Per Covered Person per Benefit Period $250

Pharmacy Out-of-Pocket Maximum

Per Covered Person per Benefit Period $2,150
Per Family per Benefit Period $4,300

The Deductible and Coinsurance are included when determining the Out-of-Pocket Maximum. Pharmacy Coinsurance is waived after satisfaction of the Pharmacy Out-of-Pocket Maximum.

The Deductible and Coinsurance are waived and the following are payable at 100%:

1. Prescribed Tier 1 contraceptives or Tier 2 if Tier 1 is unavailable;
2. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider; and
3. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/;
4. Oral Chemotherapy (fluoride treatment);
5. Navitus Complete Vaccine List.

Coinsurance after Deductible met			
Drug Type	**Retail - PBM Network**	**Member Submit***	**Mail Order**
Tier 1	30%	30%	30%
Tier 2	30%	30%	30%
Tier 3	50%	50%	50%

*For Member Submit prescriptions, the PBM will reimburse the contract cost of the prescription drug, less the applicable Coinsurance per Prescription. Contract cost is the PBM's discounted cost of the prescription drug. Reimbursement will not exceed what the PBM would have reimbursed for a Network Prescription.

COST SHARING PROVISIONS - ENHANCED PATHWAY (full incentives)

Pharmacy Deductible
Per Covered Person per Benefit Period $100

Pharmacy Out-of-Pocket Maximum
Per Covered Person per Benefit Period $2,100
Per Family per Benefit Period $4,200

The Deductible and Coinsurance are included when determining the Out-of-Pocket Maximum. Pharmacy Coinsurance is waived after satisfaction of the Pharmacy Out-of-Pocket Maximum.

The Deductible and Coinsurance are waived and the following are payable at 100%:

1. Prescribed Tier 1 contraceptives or Tier 2 if Tier 1 is unavailable;

2. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider; and

3. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/;

4. Oral Chemotherapy (fluoride treatment);

5. Navitus Complete Vaccine List.

Coinsurance after Deductible met			
Drug Type	**Retail - PBM Network**	**Member Submit***	**Mail Order**
Tier 1	20%	20%	20%
Tier 2	20%	20%	20%
Tier 3	40%	40%	40%

*For Member Submit prescriptions, the PBM will reimburse the contract cost of the prescription drug, less the applicable Coinsurance per Prescription. Contract cost is the PBM's discounted cost of the prescription drug. Reimbursement will not exceed what the PBM would have reimbursed for a Network Prescription.

COVERAGE

Coverage for prescription drugs will include only those drugs requiring a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, and that are Medically Necessary for the treatment of an Illness or Injury.

Coverage also includes prescription drugs or supplies that require a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, as follows:

1. Contraceptives that can be obtained from a pharmacy and that can be self-administered and do not require professional medical services for administering, injecting, or inserting, and over-the-counter FDA approved female contraceptives with a written prescription by a Physician or Licensed Health Care Provider. Contraceptive Management, injectable contraceptives and contraceptive devices are covered under the Medical Benefits of this Plan.

2. Erectile dysfunction: Non-injectable, limited to 9 per 28 days.

3. Weight management. Requires Prior Authorization.

4. Legend vitamins (oral only): Prenatal agents used in Pregnancy; therapeutic agents used for specific deficiencies and conditions; multivitamins; supplemental agents; and hemopoetic agents used to treat anemia.

5. Legend fluoride products (oral only): Dental or pediatric.

6. Smoking deterrents prescribed by a Physician or Licensed Health Care Provider up to two (2) 90-day supply quit attempts per Benefit Period. After the two (2) quit attempts, Coinsurance applies until the following Benefit Period.

7. Diabetic supplies including; swabs, insulin and other injectable diabetic medications, blood glucose meters and blood glucose calibration solutions, lancets and lancet devices, syringes and pen needles.

8. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

9. Vaccines. Navitus' Complete List.

10. Compounded medications.

SERVICE OPTIONS

The Program includes the following Service Options for obtaining prescriptions under the Pharmacy Benefit:

PBM Network Prescriptions: Available only through a retail pharmacy that is part of the PBM Network. The pharmacy will bill the Plan directly for that part of the prescription cost that exceeds the Coinsurance (Coinsurance amount must be paid to pharmacy at time of purchase). The prescription identification card is required for this option.

Member Submit Prescriptions: Available only if the prescription identification card cannot be used because a pharmacy is not part of the PBM Network, or the prescription identification card is not used at a PBM pharmacy. Prescriptions must be paid for at the point of purchase and the prescription drug receipt must be submitted to the PBM, along with a reimbursement form (Direct Reimbursement). The PBM will reimburse the contract cost of the prescription drug, less the applicable Coinsurance per Prescription. Contract cost is the PBM's discounted cost of the prescription drug. Reimbursement will not exceed what the PBM would have reimbursed for a Network Prescription.

Mail Order Prescriptions: Available only through a licensed pharmacy that is part of the PBM Network which fills prescriptions and delivers them to Covered Persons through the United States Postal Service, United Parcel Service or other delivery service. The pharmacy will bill the Plan directly for prescription costs that exceed the Coinsurance.

Specialty Drugs: These medications are classified by the Plan and listed by the PBM as Specialty Drugs and require special handling (e.g., most injectable drugs other than insulin). Specialty drugs must be obtained from a preferred specialty pharmacy. A list of specialty drugs and preferred specialty pharmacies may be obtained from the PBM or Third Party Administrator.

SPECIALTY COPAYMENT ASSISTANCE PROGRAM

This Plan offers a Specialty Copayment Assistance Program for certain specialty drugs included in the specialty tier and dispensed only through the specialty pharmacy, Lumicera. This program will properly manage the Covered Person's expenses for eligible specialty medications while also lowering the Plan's overall cost if copayment assistance is available. Under the program, the Covered Person's specialty medications are subject to a Copayment/coinsurance of 30%. However, this program will cap the Covered Person's total payment at $0 after utilization of available copayment assistance. Only the amount the Covered Person pays out-of-pocket will apply to the Deductible and/or Out-of-Pocket Maximum. If a specialty drug does not qualify or is removed from the program, the Covered Person's Copayment will default to the formulary's current tiered Copayment/coinsurance.

DRUG OPTIONS

Tier 1: Preferred generics and some lower cost brand products.

Tier 2: Preferred brand products and some high cost non-preferred generics.

Tier 3: Non-preferred products (could include some high cost non-preferred generics)

COINSURANCE

"Coinsurance" means a dollar amount fixed as a percentage per prescription payable by the Covered Person to the pharmacy at the time of service. Coinsurance amounts are specifically stated in this section. Coinsurance is not payable by the Plan and does not serve to satisfy the Medical Benefits Annual Deductible or Out-of-Pocket Maximum. However, Pharmacy Coinsurance does apply towards the applicable Pharmacy Out-of-Pocket Maximum and will be waived after the Pharmacy Out-of-Pocket Maximum is satisfied.

SUPPLY LIMITS

Supply is limited to ninety (90) days for PBM Network, Member Submit or Mail Order Prescriptions, and thirty (30) days for Specialty Drugs.

Prescription drug refills are not allowed until 75% of the prescribed day supply is used for Retail prescriptions or 70% for Mail Order Prescriptions.

The amount of certain medications are limited to promote safe, clinically appropriate drug usage. Any additional prescribed supply exceeding any clinically appropriate limits will be reviewed for Medical Necessity. A current list of applicable quantity limits can be obtained by contacting the PBM at the number listed on the Participant's identification card.

STEP THERAPY PROGRAM

Certain medications may require Prior Authorization before obtaining a second fill. The PBM will send a letter to the Covered Person and to the Physician to explain the steps necessary to obtain step therapy refill medications. Failure to use the step therapy program will result in the Covered Person being responsible for the entire cost of the drug.

PRIOR AUTHORIZATION

Certain drugs require approval before the drug can be dispensed. A current list of drugs that require Prior Authorization can be obtained by contacting the PBM at the number listed on the Participant's identification card.

EXCLUSIONS

Prescription drugs or supplies in the following categories are specifically excluded:

1. Cosmetic only indications including, but not limited to; photo-aged skin products (Renova2), hair growth or hair removal agents (Propecia, Vaniqa), injectable Cosmetics (Botox Cosmetic), agents used in the treatment of acne and/or for Cosmetic purposes for Covered Persons thirty-five (35) years or older or depigmentation products used for skin conditions requiring a bleaching agent.

2. Legend homeopathic drugs.

3. Fertility agents; oral, vaginal and injectable.

4. Erectile dysfunction injectables.

5. Allergens.

6. Over-the-counter equivalents and non-legend medications (OTC), except as specifically covered.

7. Blood monitors and kits.*

8. Durable Medical Equipment.*

9. Experimental or Investigational drugs.

10. Abortifacient drugs which are classified by the FDA as being used for the purpose of producing an abortion.

11. Pump Cartridge (V-Go), Pumps and Pump Supplies, and Blood Glucose and Ketone Test Strips.

*Eligible for coverage under the Medical Benefits, subject to all provisions and limitations of this Plan.

MEDICAL BENEFIT DETERMINATION REQUIREMENTS

ELIGIBLE SERVICES, TREATMENTS AND SUPPLIES

Services, treatments or supplies are eligible for coverage if they meet all of the following requirements:

1. They are administered, ordered or provided by a Physician or other eligible Licensed Health Care Provider; and

2. They are Medically Necessary for the diagnosis and treatment of an Illness or Injury or they are specifically included as a benefit if not Medically Necessary; and

3. Charges do not exceed the Eligible Expense; and

4. They are not excluded under any provision or section of this Plan.

Treatments, services or supplies excluded by this Plan may be reimbursable if such charges are approved by the Plan Administrator prior to beginning such treatment. Prior approval is limited to medically accepted non-experimental or investigational treatments, services, or supplies, which, in the opinion of the Plan Administrator, are more cost effective than a covered treatment, service or supply for the same Illness or Injury, and which benefit the Covered Person.

DEDUCTIBLE

The Deductible applies to Expenses Incurred during each Benefit Period, unless specifically waived, but it applies only once for each Covered Person within a Benefit Period. Office Visit Copayments do not apply towards the Deductible and will continue to apply after satisfaction of the Deductible. Also, if members of a Family have satisfied individual Deductible amounts that collectively equal the Deductible per Family, as stated in the Schedule of Medical Benefits, during the same Benefit Period, no further Deductible will apply to any member of that Family during that Benefit Period. An individual Covered Person cannot receive credit toward the Family Deductible for more than the Individual Annual Deductible as stated in the Schedule of Medical Benefits.

BENEFIT PERCENTAGE

The Benefit Percentage is stated in the Schedule of Medical Benefits. The Plan will pay the Benefit Percentage of the Eligible Expense indicated as the Benefit Percentage.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum, per Covered Person or Family, whichever is applicable, is stated in the Schedule of Medical Benefits and includes amounts applied toward the Deductible, amounts in excess of the Benefit Percentage paid by the Plan and all applicable Medical Benefit Copayments. Eligible Expenses Incurred in a single Benefit Period after satisfaction of the Out-of-Pocket Maximum per Covered Person or per Family, whichever is applicable, will be paid at 100% for the remainder of the Benefit Period and any applicable Office Visit Copayments will be waived for the remainder of the Benefit Period. An individual Covered Person cannot receive credit toward the Family Out-of-Pocket Maximum for more than the Individual Out-of-Pocket Maximum as stated in the Schedule of Medical Benefits. The Benefit Percentage will be reduced to 50% if the procedures for pre-certifying are not followed. This penalty does not apply to the Out-of-Pocket Maximum.

COPAYMENT

Copayments are shown in the Schedule of Medical Benefits. Copayment is a flat dollar amount paid for medical services by a Covered Person per office visit. Services which Copayments apply are payable at 100%. Applies to in-office services not to exceed $500 per office visit. These amounts apply only to charges that do not exceed the Eligible Expense. Copayments apply towards the Out-of-Pocket Maximum and will be waived after satisfaction of the Out-of-Pocket Maximum.

MAXIMUM BENEFIT

The amount payable by the Plan will not exceed any Maximum Benefit as stated in the Schedule of Medical Benefits, for any reason.

APPLICATION OF DEDUCTIBLE AND ORDER OF BENEFIT PAYMENT

Deductibles will be applied to Expenses Incurred in the chronological order in which they are adjudicated by the Plan. Expenses Incurred will be paid by the Plan in the chronological order in which they are adjudicated by the Plan. The manner in which the Deductible is applied and Expenses Incurred are paid by the Plan will be conclusive and binding on all Covered Persons and their assignees.

CHANGES IN COVERAGE CLASSIFICATION

A change in coverage that decreases a benefit of this Plan will become effective on the stated effective date of such change with regard to all Covered Persons to whom it applies.

NEW YORK STATE EXPENSES

This Plan has voluntarily elected to make public goods payments directly to the Office of Pool Administration in conformance with HCRA provisions and New York State Department of Health (Department) requirements.

MEDICAL BENEFITS

The following Medical Benefits are payable as stated in the Schedule of Medical Benefits and subject to all terms and conditions of this Plan. Medical Benefits include:

1. Charges made by a Hospital for:

   A. Daily Room and Board and general nursing services, or confinement in an Intensive Care Unit.

   B. Medically Necessary Hospital Miscellaneous Expenses other than Room and Board furnished by the Hospital, including Inpatient miscellaneous service and supplies, Outpatient Hospital treatments for chronic conditions and emergency room use for an Emergency only, Physical Therapy treatments, hemodialysis, and x-ray.

   C. Nursery neonatal units, general nursing services, including Hospital Miscellaneous Expenses for services and supplies, Physical Therapy, hemodialysis and x-ray, care or treatment of Injury or Illness, congenital defects, birth abnormalities or premature delivery incurred by a Newborn Dependent.

   D. Therapy which has been prescribed by a speech pathologist or Physician and includes a written treatment plan with estimated length of time for therapy.

      Treatment rendered for stuttering or for behavioral or learning disorders is excluded.

2. Charges made by an Ambulatory Surgical Center when treatment has been rendered.

3. Charges made by a Rehabilitation Facility.

   "Rehabilitation Facility" means a legally operating institution or distinct part of an institution which has a transfer agreement with one or more Hospitals, and which is primarily engaged in providing comprehensive, multi-disciplinary physical restorative services, post-acute Hospital and rehabilitative Inpatient care and is duly licensed by the appropriate government agency to provide such services.

   It does not include institutions which provide only minimal care, Custodial Care, ambulatory or part-time care services, or an institution which primarily provides treatment of Mental Illness or Substance Abuse/Chemical Dependency or tuberculosis, except if such facility is licensed, certified or approved as a Rehabilitation Facility for the treatment of Mental Illness or Substance Abuse/Chemical Dependency in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

4. Charges made by a Residential Treatment Facility for treatment of Mental Illness or for treatment of Substance Abuse/Chemical Dependency, provided the Substance Abuse/Chemical Dependency Treatment Facility and program meet ASAM level 3.3 or higher criteria.

   Residential care Room and Board charges are covered in lieu of Inpatient Room and Board charges provided the patient would meet criteria for an Inpatient admission.

   Residential treatment is utilized to provide structure, support and reinforcement of the treatment required to reverse the course of behavioral deterioration.

5. Charges made by an Urgent Care Facility when treatment has been rendered.

6. Charges for services and supplies furnished by a Birthing Center.

7. Charges for routine Well-Baby Newborn Inpatient Nursery/Physician Care incurred prior to discharge for a Newborn who is discharged within 48 hours following the mother's normal vaginal delivery, or less than 96 hours following the mother's cesarean section. Charges are payable as specifically stated in the Schedule of Medical Benefits for the following services:

   A. Routine Well-Baby Nursery Care includes room, board and Hospital Miscellaneous Expenses for a Newborn Dependent child.

   B. Routine Well-Baby Physician Care includes charges for services of a Physician for a Newborn Dependent child while Inpatient as a result of the child's birth.

8. Charges for circumcision whether performed as an Inpatient or Outpatient.

9. Charges made by a Skilled Nursing Facility for the following services and supplies furnished by the facility. Only charges in connection with convalescence from the Illness or Injury for which the Covered Person was Hospital-confined will be eligible for benefits. These expenses include:

   A. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services.

   B. Medical services customarily provided by the Skilled Nursing Facility, with the exception of private duty or special nursing services and Physicians' fees.

   C. Drugs, biologicals, solutions, dressings and casts, furnished for use during the convalescent confinement, but no other supplies.

10. Charges made by a Hospice within any one Hospice Benefit Period for:

    A. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services.

    B. Nursing care by a Registered Nurse (RN), a Licensed Practical Nurse (LPN), a public health nurse who is under the direct supervision of a Registered Nurse.

    C. Physical Therapy and Speech Therapy, when rendered by a licensed therapist.

    D. Medical supplies, including drugs and biologicals and the use of medical appliances.

    E. Physician's services.

    F. Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.

    G. Bereavement counseling.

11. Charges for the services of a licensed Physician or Licensed Health Care Provider for medical care and/or treatments, including office, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care, and surgical opinion consultations.

    Charges are eligible for drugs intended for use in a Physicians' office or settings other than home use that are billed during the course of an evaluation or management encounter.

12. Charges for chiropractic services.

13. Charges for Manipulation Under Anesthesia (MUA) only for frozen shoulder when performed by an orthopedist. All other MUA is not covered. Chiropractic services do not include MUA.

14. Charges for family counseling or marital counseling.

15. Charges for Medically Necessary treatment of the feet, including treatment of metabolic or peripheral-vascular disease.

16. Charges for weight loss program. The program must be under the supervision of a licensed Physician. Patient must have a diagnosis of Morbid Obesity. Eligible Expenses include Physician office visits and services provided by the weight loss clinics, such as FDA approved medications, supplements, injections, blood pressure monitoring and dietary counseling.

17. Charges for Pregnancy, including charges for prenatal care, childbirth, miscarriage, and any medical complications arising out of or resulting from Pregnancy for an Employee or spouse only. Charges for Pregnancy of a covered Dependent daughter are excluded. Charges for Pregnancy for a Dependent daughter are covered only for prenatal well-women care as a recommended preventive service under the Preventive Care Benefit.

18. Charges for termination of Pregnancy for an Employee or spouse only, when the life of the mother would be endangered if the fetus were carried to term.

19. Charges for Surgical Procedures for Out-of-Network Providers.

    When two or more Surgical Procedures occur during the same operative session, charges will be considered as follows:

    A. When multiple or bilateral Surgical Procedures are performed that increase the time and amount of patient care, 100% of the Eligible Expense will be considered for the Major Procedure; and 50% of the Eligible Expense will be considered for each of the lesser procedures, except for contracted or negotiated services. Contracted or negotiated services will be reimbursed at the contracted or negotiated rate.

    B. When an incidental procedure is performed through the same incision, only the Eligible Expense for the Major Procedure will be considered. Examples of incidental procedures are: excision of a scar, appendectomy at the time of other abdominal surgery, lysis of adhesions, etc.

    When an assisting Physician is required to render technical assistance during a Surgical Procedure, the charges for such services will be limited to 20% of the primary surgeon's Eligible Expense for the Surgical Procedure. When an assisting non-physician is required to render technical assistance during an operation, charges for such services will be limited to 20% of the surgeon’s Eligible Expense for the Surgical Procedure.

    For In-network providers payment will be made pursuant to the provider contract.

20. Charges for Registered Nurses (RNs) or Licensed Practical Nurses (LPNs) for private duty nursing.

21. Charges for midwife services by a Certified Nurse Midwife (CNM) who is a registered nurse and enrolled in either the certification maintenance program or the continuing competency assessment program through the American College of Nurse Midwives (ACNM).

22. Charges for dental treatment when dental condition is likely to result in a medical condition if left untreated. Prior-authorization from the Third Party Administrator is required. Also when Medically Necessary coverage is provided for hospitalization and anesthesia for such conditions if the Covered Person is under eight (8) years of age or has one or more medical conditions that would create significant or undue medical risk for the Covered Person.

23. Charges for oral surgery performed by a Dentist or Physician due to an Accidental Injury to a Covered Person's jaw or natural teeth including Prosthetic Appliances. This includes replacement of teeth and any related x-rays. The treatment must begin within ninety (90) days of the Accidental Injury to be covered. Charges required for dental care not otherwise covered are eligible only if Medically Necessary due to a life threatening Illness or disease or congenital abnormality.

24. Charges for reconstructive surgery when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part or to correct damage caused by an Accidental Injury.

25. Charges for home and Outpatient infusion services ordered by a Physician and provided by a Home and Outpatient Infusion Therapy Organization licensed and approved within the state in which the services are provided. A "Home and Outpatient Infusion Therapy Organization" is a health care facility that provides home and Outpatient infusion therapy services and skilled nursing services. Home and Outpatient infusion therapy services include the preparation, administration, or furnishing of parenteral medications, or parenteral or enteral nutritional services to a Covered Person by a Home and Outpatient Infusion Therapy Organization. Services also include education for the Covered Person, the Covered Person's care giver, or a family member. Home and Outpatient infusion therapy services include pharmacy, supplies, equipment and skilled nursing services when billed by a Home and Outpatient Infusion Therapy Organization.

    Skilled nursing services billed by a Home Health Care Agency are covered under the Home Health Care Benefit.

26. Charges for Physical Therapy or Occupational Therapy whose primary purpose is to provide medical care for an Illness or Injury, on an Inpatient or Outpatient basis. Physical Therapy or Occupational Therapy must be rendered by a licensed physical or occupational therapist. Visits exceeding twelve (12) must be ordered by a Physician.

27. Charges for massage therapy in conjunction with Physical Therapy performed by a licensed Physical Therapist.

28. Charges made by a licensed speech therapist for Speech Therapy, also called speech pathology, and audio diagnostic testing services for diagnosis and treatment of speech and language disorders. The Plan will provide benefits for Speech Therapy when all of the following criteria are met:

    A. There is a documented condition or delay in development that can be expected to improve with therapy within a reasonable time.

    B. Improvement would not normally be expected to occur without intervention.

    C. Treatment is not rendered for stuttering.

    D. Treatment is not rendered for behavioral or learning disorders.

    E. Treatment is rendered for a condition that is the direct result of a diagnosed neurological, muscular, or structural abnormality affecting the organs of speech.

    F. Therapy has been prescribed by the speech language pathologist or Physician and includes a written treatment plan with estimated length of time for therapy, along with a statement certifying all above conditions are met.

29. Charges for Ambulance Service to the nearest facility where Emergency care or treatment can be rendered; or from one facility to another for care; or from a facility to the patient's home when Medically Necessary.

30. Charges for drugs requiring the written prescription of a Physician or a Licensed Health Care Provider and Medically Necessary for the treatment of an Illness or Injury. Coverage also includes prescription contraceptive drugs not available through the Pharmacy Benefit regardless of Medical Necessity and FDA approved over-the-counter female contraceptives prescribed by a Physician or Licensed Health Care Provider.

    Conditions of coverage for Outpatient prescription drugs and supplies available through the Pharmacy Benefit are as stated in the Pharmacy Benefit section of the Plan.

31. Charges for x-rays, CAT scans, MRIs, microscopic tests, and laboratory tests.

32. Charges for radiation therapy or treatment and chemotherapy.

33. Charges for blood transfusions, blood processing costs, blood transport charges, blood handling charges, administration charges, and the cost of blood, plasma and blood derivatives. Any credit allowable for replacement of blood plasma by donor or blood insurance will be deducted from the total Eligible Expense.

34. Charges for oxygen and other gases and their administration.

35. Charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally accepted by Physicians throughout the United States.

36. Charges for the cost and administration of an anesthetic.

37. Charges by a Physician or Licensed Health Care Provider for dressings, sutures, casts, splints, trusses, crutches, braces, adhesive tape, bandages, antiseptics, jobst garments, or other Medically Necessary medical supplies.

38. Charges for treatment of Diabetes, including Medically Necessary and appropriate equipment, supplies and services to treat diabetes, and Outpatient self-management training and education services. Diabetic supplies are eligible as stated under the Pharmacy Benefit of this Plan.

39. Charges for treatment of or related to eating disorders.

40. Charges for treatment of or related to sleep disorders.

41. Charges for Durable Medical Equipment, Orthopedic Appliances, or Prosthetic Appliances as follows:

    A. Rental, up to the purchase price, of a wheelchair, Hospital bed, respirator or other Durable Medical Equipment required for therapeutic use, or the purchase of this equipment if economically justified, whichever is less. If there is a known medical reason to rent rather than purchase Durable Medical Equipment, then rental is allowed up to the purchase price.

    B. Purchase of Orthopedic Appliances or Prosthetic Appliances including, but not limited to, artificial limbs, eyes, larynx.

    C. Replacement or repair of Durable Medical Equipment, Orthopedic Appliances, Prosthetic Appliances. Replacement will be covered if the replacement is required due to a change in the patient's physical condition; or purchase of new equipment will be less expensive than repair of existing equipment.

42. Charges for vasectomy. Sterilization procedures for women are covered under the Preventive Care Benefit.

43. Reasonable charges for producing medical records only if incurred for the purpose of utilization review, audits or investigating a claim for benefits if requested and approved by the Plan. Charges that exceed limits for such charges imposed by applicable law will not be deemed to be reasonable.

44. Charges for Contraceptive Management, regardless of Medical Necessity. "Contraceptive Management" means Physician fees related to a prescriptive contraceptive device, obtaining a prescription for contraceptives, purchasing, fitting, injecting, implantation or placement of any contraceptive device or removal of any device.

45. Charges for wigs or artificial hairpieces only if loss of hair a result of chemotherapy or other similar medical treatment.

46. Charges for orthopedic or corrective shoes and other supportive appliances for the feet when prescribed by a Physician.

47. Charges for initial prescription contact lenses or eyeglasses, including the examination and fitting of the lenses, to replace the human lens lost through cataract surgery.

48. Charges for genetic testing, limited to the following genetic testing procedures:

    A. Flow Cytometry;
    B. FISH: Manual, Automated and UroVysion;
    C. Cytogenetics;
    D. Molecular: B&T cell gene rearrangement;
    E. Molecular: JAK2 MPN Reflex Panel;
    F. Molecular: BCR/ABL;
    G. Molecular: PML/RARA;
    H. Molecular: NPM1.
    I. Molecular: EGFR
    J. EER2;
    K. KRAS;
    L. CCR5
    M. HCV

49. Charges for "Routine Patient Costs" for a Phase I "Approved Clinical Trial" for "Qualified Individuals".

    "Routine Patient Costs" include but are limited to Medically Necessary services which a Covered Person with the identical diagnosis and current condition would receive even in the absence of participating in an Approved Clinical Trial.

    "Routine Patient Costs" do not include any investigational item, device, or service that is part of the Approved Clinical Trial; an item or service provided solely to satisfy data collection and analysis needs for the trial if the item or service is not used in the direct clinical management of the patient; a service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis; or an item or service customarily provided and paid for by the sponsor of an Approved Clinical Trial.

    "Approved Clinical Trial" means a Phase I clinical trial that is conducted in relation to the prevention, detection, or treatment of an acutely life-threatening disease state and is not designed exclusively to test toxicity or disease pathophysiology. The Approved Clinical Trial must be:

    A. Conducted under an investigational new drug application reviewed by the United States Food and Drug Administration;

    B. Exempt from obtaining an investigational new drug application; or

C. Approved or funded by:

1) The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services, or a cooperative group or center of any of the entities described above;
2) A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;
3) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support groups; or
4) The United States Departments of Veterans Affairs, Defense, or Energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States Secretary of Health and Human Services to:

a) Be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
b) Provide unbiased scientific review by individuals who have no interest in the outcome of the review.

A "Qualified Individual" is a Covered Person who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the treatment of an acutely life-threatening disease state and either (i) the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate, or (ii) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

50. Charges for acupuncture or naturopathy treatment provided by a legally qualified provider practicing within the scope of his or her license. **Benefit limits apply as stated in the Schedule of Medical Benefits.**

51. Charges for the initial purchase of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary surgical procedure to the eye, cataract surgery or for aphakic patients, soft lenses or sclera shells intended for use as corneal bandages.

52. Charges for services that are related to or as a result of Telemedicine, limited to the following methods:

A. An interactive patient encounter between the Physician or Licensed Health Care Provider being consulted and the patient. This method requires a "live" two way video and audio transmission between the patient and the Physician or Licensed Health Care Provider, and may include one additional provider who is presenting the patient to a specialist for an opinion regarding the patient's condition. **Expenses billed for the use of equipment or transmission charges to transmit the audiovisual information are not covered.**

B. Storing and forwarding medical documentation to a licensed Radiologist or Pathologist for the purpose of reviewing telecommunicated medical documentation at a time which is convenient to the Radiologist or Pathologist's schedule. This method does not require actual contact between the patient and the provider. **Expenses billed for the use of equipment or transmission charges to transmit the audiovisual information are not covered.**

Telemedicine does not include charges for teleconsultations, which involves a practitioner seeking advice from a consultant concerning a patient's condition or course of treatment.

It is understood that the provider of medical information and advice through the telemedicine program is not the Covered Person's Primary Care Physician.

Telemedicine other than MDLive consultations are not covered except for Telemedicine provided under the Emotional Wellness Program through CHP as stated in the Schedule of Medical Benefits.

53. Charges for emotional wellness counseling program services and support through Community Health Partners (CHP). For further information regarding the Emotional Wellness Program or to schedule an appointment call (239) 659-7751.

54 Charges for laser therapy for treatment of plantar faciitis.

HEARING AIDS AND EXAMINATION

Benefit limits apply as stated in the Schedule of Medical Benefits.

Coverage includes charges for services or supplies in connection with hearing aids, including routine hearing examinations, the fitting of hearing aids, repairs and replacement of hearing aids and batteries. Services must be rendered by a licensed audiologist.

HOME HEALTH CARE BENEFIT

Coverage under this benefit includes charges made by a Home Health Care Agency for care in accordance with a Home Health Care Plan for the following services:

1. Part-time or intermittent nursing care by a Registered Nurse (RN) or by a Licensed Practical Nurse (LPN), a vocational nurse, or public health nurse who is under the direct supervision of a Registered Nurse;

2. Home health aides;

3. Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital.

Home Health Care specifically excludes the following:

1. Services and supplies not included in the approved Home Health Care Plan.

2. Services of a person who ordinarily resides in the home of the Covered Person, or who is a Close Relative of the Covered Person who does not regularly charge the Covered Person for services.

3. Services of any social worker.

4. Transportation services.

5. Housekeeping services.

6. Custodial Care.

INBORN ERRORS OF METABOLISM

“Inborn Errors of Metabolism” are a set of conditions and diagnoses related to the inability to digest and metabolize food. Coverage under this benefit includes charges for treatment under the supervision of Physician for Inborn Errors of Metabolism that involve amino acid, carbohydrate and fat metabolism, and for which medically standard methods of diagnosis, treatment and monitoring exist. Benefits include expenses of diagnosing, monitoring and controlling the disorders by nutritional and medical assessment including, but not limited to, clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the Inborn Error of Metabolism, nutritional management, and Medical Foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

"Medical Foods" means any nutritional substances in any form that are:

1. Formulated to be consumed or administered enterally under supervision of Physician;

2. Specifically processed or formulated to be distinct in one or more nutrients present in natural food;

3. Intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and

4. Essential to optimize growth, health, and metabolic homeostasis.

MENTAL ILLNESS

Coverage under this benefit includes the following services:

1. Physician or Licensed Health Care Provider charges for diagnosis and Medically Necessary Psychiatric Care and treatment including, but not limited to, group therapy.

2. Charges for well-established medically accepted diagnostic testing generally accepted by Physicians in the United States.

3. Charges for Inpatient or Partial Hospitalization, for Medically Necessary treatment, for the same services as are covered for hospitalization for physical Illness or Injury by this Plan.

4. Charges for Medically Necessary treatment at a Psychiatric Facility.

ORGAN OR TISSUE TRANSPLANT PROCEDURE

Benefit limits apply as stated in the Schedule of Medical Benefits.

Charges in connection with non-Experimental or non-Investigational organ or tissue transplant procedures, subject to the following conditions:

1. The transplantation procedure has been approved by Community Health Partners and the procedure is being performed at a facility approved by the Community Health Partners. Transplantation includes pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation. Benefits are payable only for services, care and treatment received for or in connection with the approved transplantation. Benefits are payable only if the pre-transplant services, the transplant procedure and post-discharge services are performed in an approved facility.

2. Once the transplant procedure is approved, the attending Physician will be advised of those facilities that have been approved for the type of transplant procedure involved.

3. For approved transplant procedures and all related complications, the Plan will only cover the following services for all transplant procedures shown in the Schedule of Medical Benefits:

   A. Hospital services and medical services will be paid under the Hospital services and medical services provisions in this group Plan, in accordance with the same terms and conditions as benefits are payable for care and treatment of any other covered condition.

4. If the donor is covered under this Plan, Expenses Incurred by the donor will be considered for benefits to the extent that such expenses are not payable by the recipient's plan.

5. If the recipient is covered under this Plan, Expenses Incurred by the recipient will be considered for benefits. Expenses Incurred by the donor, who is not ordinarily covered under this Plan according to eligibility requirements, will be considered for payment to the extent that such expenses are not payable by the donor's plan. In no event will benefits be payable in excess of the benefit limits still available to the recipient.

6. If both the donor and the recipient are covered under this Plan, Expenses Incurred by each person will be treated separately for each person.

No benefit is payable for or in connection with a transplant if:

1. Authorization is not provided prior to referral for transplant evaluation of the procedure.

2. Coverage for the procedure was not approved.

3. The transplant procedure is performed in a facility that has not been designated as an approved transplant facility.

4. The costs of the services are eligible to be paid under any private or public research fund, government program.

5. The service related to the transplantation of any non-human organ or tissue.

6. A denied transplant is performed; this includes follow-up care, immunosuppressive drugs, and complications of such transplant.

7. Artificial heart devices used as a bridge to transplant.

PRENATAL/PARENTAL EDUCATION

Coverage includes charges for prenatal/parental education classes. Parent education programs focus on enhancing parenting practices and behaviors such as, developing and practicing positive discipline techniques, learning age-appropriate child development skills and milestones, promoting positive play and interaction between parents and children, and locating and accessing community services and supports.

PREVENTIVE CARE

“Preventive Care” means routine treatment or examination provided when there is no objective indication or outward manifestation of impairment of normal health or normal bodily function, and which is not provided as a result of any Injury or Illness.

Coverage under this benefit includes the following routine services, subject to the following limitations:

1. Routine Wellness care for children and adults for the following:

   A. Routine physical examinations by a Physician or Licensed Health Care Provider, which will include a medical history, physical examination, developmental assessment, and anticipatory guidance as directed by a Physician or Licensed Health Care Provider and associated routine testing provided or ordered at the time of the examination; and

   B. Routine immunizations according to the schedule of immunizations which is recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention.

2. All Pathway required screenings and procedures.

3. Recommended preventive services as set forth in the recommendations of the United States Preventive Services Task Force (Grade A and B rating), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the guidelines supported by the Health Resources and Services Administration. The complete list of recommendations and guidelines can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

4. Office visit charges only if the primary purpose of the office visit is to obtain a recommended Preventive Care service identified above.

5. Women's Preventive Care for the following:

   A. Well-women annual visits for women 18 years of age and older to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care, and additional visits as medically appropriate.

   B. Screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.

   C. Human papillomavirus (HPV) DNA testing.

   D. Annual counseling on sexually transmitted infections (STI's) and human immune-deficiency virus (HIV) screening for all sexually active women.

   E. All Food and Drug Administration approved prescription contraceptives and female over-the-counter contraceptives when prescribed by a Physician or Licensed Health Care Provider, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs. Self-administered contraceptives are available only through the Pharmacy Benefit as outlined in the Pharmacy Benefit section of this Plan.

   F. Breast feeding support, supplies, and counseling, including comprehensive lactation support and counseling by a trained provider during Pregnancy and/or in the postpartum period, and costs for breast feeding equipment and related supplies.

   G. Annual screening and counseling for interpersonal and domestic violence.

Expenses payable under this Preventive Care Benefit will not be subject to the Medical Necessity provisions of this Plan. Charges for Preventive Care that involve excessive, unnecessary or duplicate tests are specifically excluded.

Charges for treatment of an active Illness or Injury are subject to the Plan provisions, limitations and exclusions and are not eligible in any manner under Preventive Care.

RECONSTRUCTIVE BREAST SURGERY/NON-SURGICAL AFTER CARE BENEFIT

Coverage includes charges for reconstructive breast surgery subsequent to any Medically Necessary mastectomy, limited to charges for the following:

1. Reconstruction of the breast(s) upon which the mastectomy was performed, including implants;

2. Surgical procedures and reconstruction of the non-affected breast to produce a symmetrical appearance, including implants;

3. Non-surgical treatment of lymphedemas and other physical complications of mastectomy, including non-surgical prostheses and implants for producing symmetry.

4. Mastectomy bra, limited to four (4) per benefit period.

Specifically excluded from this benefit are expenses for the following:

1. Solely Cosmetic procedures unrelated to producing a symmetrical appearance;

2. Breast augmentation procedures unrelated to producing a symmetrical appearance;

3. Implants for the non-affected breast unrelated to producing a symmetrical appearance;

4. Non-surgical prostheses or any other procedure unrelated to producing a symmetrical appearance.

SUBSTANCE ABUSE/CHEMICAL DEPENDENCY

Coverage under this benefit includes the following services:

1. Physician or Licensed Health Care Provider charges for diagnosis and Medically Necessary treatment including, but not limited to, group therapy.

2. Charges for well-established medically accepted diagnostic testing generally accepted by Physicians in the United States.

3. Charges for Inpatient or Partial Hospitalization, for Medically Necessary treatment, for the same services as are covered for hospitalization for physical Illness or Injury by this Plan.

4. Charges for Medically Necessary treatment, including aftercare, at a Substance Abuse/Chemical Dependency Treatment Facility.

WEIGHT LOSS SURGERY PROGRAM

A Covered Person must enroll in the Weight Loss Surgery Program through Community Health Partners and actively participate for six (6) consecutive months prior to consideration for pre-certification of any gastric bypass surgery and six (6) consecutive months following the surgery. Surgery must be performed immediately after completing the six (6) month program.

Recommendation regarding request for gastric procedures limited to: Bariatric Surgery, Gastric Stapling, Laparoscopic Gastric Bypass, Roux-en-Y Gastric Bypass (RYGB), Vertical Banded Gastroplasty (VBG), Gastric Sleeve Surgery (Vertical Sleeve Gastrectomy) or intragastric balloon procedure.

The following criteria will be used for pre-certifying benefits for the above procedures:

1. A clinical history of unsuccessful diet and other weight management programs.

2. Must receive a positive assessment of surgery risk-benefit from all evaluating staff members of the pre-surgery program.

3. Must be at least 18 years of age and less than 70 years of age.

The following is specifically excluded:

1. Surgical procedures except for Bariatric Surgery, Gastric Stapling, Laparoscopic Gastric Bypass, Roux-en-Y Gastric Bypass (RYGB), Vertical Banded Gastroplasty (VBG), Gastric Sleeve Surgery (Vertical Sleeve Gastrectomy) or intragastric balloon procedure.

2. Any Expenses Incurred for which all of the conditions of the Weight Loss Surgery Program have not been met.

3. Any redo or revision of a prior weight loss surgical procedure.

4. A second weight loss surgical procedure, whether or not the first procedure was performed while covered under this Plan or not.

Additional information and prior authorization is provided by calling Community Health Partners at (239) 659-7770.

EXPERIMENTAL COVERAGE

Treatment that would otherwise be considered Experimental/Investigational will be covered only if the proposed Experimental/Investigational treatment has been reviewed by four (4) unrelated, independent board certified Physicians actively practicing within the same specialty as the attending Physician and the four (4) reviewing Physicians have unanimously agreed that:

1. As a result of the rarity of the disease or condition, there is no United States FDA approved regimen of treatment;

2. All United States FDA approved regimens of treatment have been attempted within the twelve (12) month period immediately prior to the date the proposed experimental treatment is to commence without any significant clinical improvement in the disease or condition;

3. The proposed course of treatment is medically indicated and is considered the standard of care in the United States for the disease or condition being treated based upon published reports and articles in the authoritative medical and scientific literature including, but not limited to, the following:

    A. The written protocol or protocols used by the treating facility or the protocols of another facility studying substantially the same drug, treatment, device or procedure; and

    B. The informed consent documents used by the treating facility or of another facility studying substantially the same drug, treatment, device or procedure; and

4. To a reasonable degree of medical certainty, there is a likelihood that the proposed treatment will clinically improve the condition being treated; and

5. That the patient is not considered to be terminal regardless of the treatment proposed or attempted; or

6. The treatment has been recognized by the National Comprehensive Cancer Network (NCCN) as the only available treatment that has demonstrated efficacy of the condition in question.

NOTIFICATION PROVISIONS
Community Health Partners
(239) 659-7770 or (888)-594-9008

To ensure the most appropriate care is provided, and to control the costs of this Plan, the Plan contains a notification provision. The notification provision requires that a Covered Person call Community Health Partners (CHP) **at least twenty-four (24) hours before:**

1. All elective (non-urgent, pre-arranged, non-emergency) Inpatient admissions in a Hospital, Hospice, Skilled Nursing, Rehabilitation or Chemical Dependency/Mental Illness Treatment Facilities. This does not apply to Hospital admissions in connection with childbirth for the mother or newborn for any hospital length of stay longer than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section.

2. Any of the following that are done on an Outpatient basis:

   A. Blepharoplasty.

   B. Breast reduction.

   C. CAT Scans, MRI, MRA, PET Scan and all CT guided procedures.

   D. Durable Medical Equipment with cost anticipated in excess of $500 for rental or purchase.

3. Home Health Care in excess of five (5) visits for skilled nursing visits, home Physical, Occupational and Speech therapy.

4. Pain management (epidurals, facet blocks and nerve stimulators). Epidurals limited to six (6) per Benefit Period.

5. Outpatient rehabilitation services in excess of 12 visits per discipline for Physical Therapy, Speech Therapy or Occupational Therapy.

6. All transplants, including the initial consultation, evaluation and actual transplant.

7. When an Observation Stay is greater than twenty-four (24) hours (greater than one midnight) or converts to an Inpatient admission.

   "Observation Stay" is an alternative to an Inpatient admission that allows reasonable and necessary time to evaluate and render Medically Necessary services to a patient whose diagnosis and treatment are not expected to exceed twenty-four (24) hours but may extend to forty-eight (48) hours, and the need for an Inpatient admission can be determined within this specific period. An Inpatient admission is generally appropriate when the patient is expected to need two (2) or more midnights of Medically Necessary Hospital care.

8. Gender Identity Disorder/Gender Dysphoria Surgery.

Pre-notification is not required if any one of these procedures is performed in the emergency room.

For a non-emergency hospitalization, CHP will evaluate the proposed admission plan and length of stay. CHP will certify the number of days appropriate. In making these determinations, the diagnosis, physical status and any other complicating conditions of the patient will be taken into account. CHP will review any x-ray and laboratory results and confer with the attending Physician if necessary. The decision to be admitted will always rest with the patient and the Physician. The notification process will let the patient know, before expenses are incurred, whether or not the admission would be certified. Benefits will only be available for the number of days that have been certified. If the confinement will last longer than the number of days certified, CHP must be notified. At this point, CHP will conduct a Continued Stay Review. The Continued Stay Review will be conducted in much the same way as the initial notification. The case will be reviewed with the attending Physician to determine any additional Inpatient days. Benefits will not be available for any days beyond those certified.

If a Covered Person is admitted to the Hospital or receives any of the services listed above on an Emergency Outpatient basis, the Covered Person must call CHP within forty-eight (48) hours following the admission, test, or procedure. (If emergency admission occurs on a weekend or holiday, notification can be extended to the first business day following the emergency admission).

Notification can come from the Covered Person, the Hospital, or the Physician. However, the Covered Person is ultimately responsible for the notification. It is strongly recommended, therefore, that the Covered Person makes the call. If the patient is unconscious, in a coma or unable to contact CHP due to Illness or Injury rendering the patient physically or mentally incapable, the notification requirement will be waived until the patient is able to contact CHP. Certification will be retroactive to the date of admission.

Notification requires only a brief phone call to CHP at (239) 659-7770 or toll free at (888) 594-9008. If the call is made after hours, the following information must be left on CHP's confidential voice mail:

1. Employee's name.
2. Employee ID number.
3. Patient's name and relationship to the Employee.
4. The name of the Hospital where the procedure will take place (if applicable).
5. The procedure to be performed.
6. The name and telephone number of the Physician.

It is vital the call occurs within the time frames list above. If notification is not made, the Benefit Percentage payable will be reduced to 50% for all related Eligible Expenses, after any applicable Deductible. The penalty assessed when notification is not made does not apply towards the Out-of-Pocket Maximum.

If notification is not provided within the times outlined, CHP will review the claim to determine whether the admission, test, or procedure was Medically Necessary. Irrespective of the eventual determination by CHP, the penalty will still be applied and cannot be rescinded.

Hospital stays in connection with childbirth for either the mother or Newborn may not be less than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to notify CHP of the maternity admission, unless the stay extends past the applicable forty-eight (48) or ninety-six (96) hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the Newborn or mother is admitted to a Hospital following birth, in connection with childbirth.

ONCOLOGY PRE-TREATMENT REVIEW

For oncology claims only, Pre-treatment Review is strongly recommended. To obtain Pre-Treatment Review for oncology claims, please follow the procedure outlined below.

1. ONCOLOGY MEDICAL MANAGEMENT PROGRAM: CARE INTEGRATION

   In order to initiate oncology management services, the Covered Person's oncologist should contact the Third Party Administrator at (800) 877-1122 to verify plan benefits. At that time, the oncologist will be asked to contact Allegiance Care Management at (877) 791-7827 and to provide a copy of the treatment plan that oncologist has prescribed for the Covered Person (including chemotherapy and radiation provided in any setting). Allegiance Care Management will remain in contact with the Covered Person and the oncologist for the duration of the treatment plan through recovery and transitional care. Please call (877) 791-7827 for questions regarding cancer care, side affects and other quality of life issues.

   In order to receive benefit payments under the Plan, the oncologist's oncology plan of treatment must be received by Allegiance Care Management, and deemed not to be Experimental and/or Investigational as described below. The Plan may not pay for or otherwise cover the cost of oncology related treatment considered Experimental and/or Investigational as defined by the Plan.

   Unless the oncologist has entered into an agreement with Allegiance Care Management to accept other reimbursement rates, the payment for all drugs used in the treatment of cancer will be limited to the rate of Average Sales Price plus 10%. Average Sales Price is updated quarterly by Medicare.

2. EXPERIMENTAL AND/OR INVESTIGATIONAL

   The Plan may not pay for or otherwise cover the cost of oncology related treatment considered Experimental and/or Investigational. For purposes of oncology drugs only, Experimental and or Investigational is defined as:

   In the context of drugs used in the treatment of cancer, the use of a drug will not be considered Experimental and/or Investigational where (1) the use of the drug has been recognized as safe and effective for the treatment of the specific type of cancer in the National Comprehensive Cancer Network's Drugs Compendium, Thomson Micromedex DRUGDEX, Thomson Micromedex DrugPoints or clinical Pharmacology or (2) the drug is provided in association with a Phase III or IV trial for cancer, as approved by the FDA or sanctioned by the National Cancer Institute ("NCI") or (3) the drug is provided in association with a Phase II trial for cancer by an NCI-sponsored group and standard treatment has been or would be ineffective or does not exist or there is no clearly superior non-investigational alternative that can be delivered more cost efficiently as determined by the Plan Administrator.

MANDATORY CASE MANAGEMENT

Community Health Partners (CHP) will monitor a Covered Person's emerging risk, a condition or diagnosis that may be potentially significant by utilizing several different methods such as Verisk Medical Intelligence, Notification request, Pharmacy and TPA reports.

When a Covered Person has been identified with emerging risk they will be encouraged to enroll in Case Management and actively participate in their care plan. Active participation is described as, communicating with their Case Manager on a weekly basis until less intensity is needed determined by the Case Manager or the Covered Person is disenrolled from program. Communication may be in the form of letters, phone calls, face to face meetings or encrypted emails. If a Covered Person cancels an appointment with the case manager, it is the Covered Person's responsibility to reschedule within 48 business hours. If a Covered Person refuses to participate and their level of medical and pharmacy expenses combined exceeds $100,000 in a six (6) month period, they will receive a monetary benefit adjustment for failure to participate.

First Contact: Covered Persons will be contacted by a Case Manager as soon as a trend is identified to enroll the Covered Person into Case Management. Initially a letter will be sent from Community Health Partners advising the Covered Person they have been identified to participate in Case Management and will be contacted within one week. The letter will provide the Case Manager's contact information and ask the Covered Person to be pro-active and reach out to the case manager and communicate the best time to schedule a call with the Covered Person.

Second Contact: If no-response, the Case Manager will confirm with the Human Resource Department that they have the most current contact information. A second call will be place within 48 business hours.

Third Contact: Third call will be place to the Covered Person within another 48 business hour cycle. This call will be placed after normal business hours between 5 and 7pm.

Fourth contact: Certified letter requiring a signature will be sent to the Covered Person's current home address. This letter will outline the attempts made to contact the Covered Person as well as the potential benefit adjustment due to failure to participate.

MEDICAL BENEFIT EXCLUSIONS

The General Plan Exclusions and Limitations of the Plan apply to Medical Benefits in addition to the following Medical Benefit Exclusions:

1. Charges for routine medical examinations, routine health check-ups or preventive immunizations not necessary for the treatment of an Injury or Illness, except as specifically listed as a covered benefit.

2. Charges in connection with the care or treatment of, surgery performed for, or as the result of, a Cosmetic procedure. This exclusion will not apply when such treatment is rendered to correct a condition resulting from an Accidental Injury or an Illness, or when rendered to correct a congenital anomaly.

3. Charges for services, supplies or treatments or procedures, surgical or otherwise, not recognized as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury, or which are Experimental or Investigational, except as specifically stated as a covered benefit of this Plan.

4. Charges for elective abortions.

5. Charges for Pregnancy of a covered Dependent daughter except for prenatal well-women care as a recommended preventive service under the Preventive Care Benefit.

6. Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations, tests or treatments not connected with the actual Illness or Injury.

7. Charges for Physicians' fees for any treatment which is not rendered by or in the physical presence of a Physician, except for Telemedicine.

8. Charges for Licensed Health Care Providers' fees for any treatment which is not rendered by or in the physical presence of a Licensed Health Care Provider, except for Telemedicine.

9. Charges for special duty nursing services are excluded:

   A. Which would ordinarily be provided by the Hospital staff or its Intensive Care Unit (the Hospital benefit of the Plan pays for general nursing services by Hospital staff); or

   B. When private duty nurse is employed solely for the convenience of the patient or the patient's Family or for services which would consist primarily of bathing, feeding, exercising, homemaking, moving the patient, giving medication or acting as a companion, sitter or when otherwise deemed not Medically Necessary as requiring skilled nursing care.

10. Charges in connection with eye refractions, the purchase or fitting of eyeglasses or contact lenses, except as specifically listed as a covered service.

11. Charges for dental treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes; however, benefits will be payable for treatment required because of Accidental Injury to natural teeth. See Medical Benefits for further details.

12. Charges related to or in connection with fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, or in-vitro fertilization, or any other assisted reproductive technique.

13. Charges for recreational counseling or milieu therapy.

14. Charges resulting from or in connection with the reversal of a sterilization procedure.

15. Charges in connection with services or supplies provided for the surgical treatment of obesity and weight reduction, except as otherwise covered under the Weight Loss Surgery Program.

16. Charges for chiropractic treatment which are not related to an actual Illness or Injury or which exceed the maximum benefit as stated in the Schedule of Medical Benefits.

17. Charges for holistic medical procedures or rolfing, except as specifically covered.

18. Charges for hair transplant procedures, wigs and artificial hairpieces, or drugs which are prescribed to promote hair growth or remove hair. Wigs or hairpieces are covered only if loss of hair a result of chemotherapy or other similar medical treatment.

19. Charges for any services, care or treatment for sexual dysfunction, including related drugs, medications, surgery, medical or Psychiatric Care or treatment, except as specifically stated in the Pharmacy Benefit.

20. Charges for treatment of Gender Identity Disorder/Gender Dysphoria when the services are for reversal of a prior gender reassignment surgery or reversal of a prior surgery to revise secondary sex characteristics.

21. Charges for any surgical, medical or Hospital services and/or supplies rendered in connection with radial keratotomy, LASIK or any other procedure designed to correct farsightedness, nearsightedness or astigmatism.

22. Charges related to Custodial Care.

23. Charges related to insertion or maintenance of an artificial organ.

24. Charges for non-prescription supplies or devices, except as covered under the Preventive Care Benefit.

25. Charges for services of a Direct-entry Midwife or lay midwife or the practice of Direct-entry Midwifery.

    “Direct-entry Midwife” means a person who advises, attends, or assists a woman during Pregnancy, labor, natural childbirth, or the postpartum period and who is not a licensed Certified Nurse Midwife.

26. Charges for non-surgical treatment of the feet, including treatment of corns, calluses and toenails, or other routine foot care.

27. Charges for genetic counseling or testing, except as specifically listed as covered expense or covered under the Preventive Care Benefit.

28. Charges for hypnosis.

29. Charges for occupational therapy supplies.

30. Charges for surrogate expenses.

31. Charges for treatment of behavioral or conduct disorders, except as specifically required by Mental Health Parity.

32. Charges for complications that directly result from acting against medical advice, non-compliance with specific Physician's orders or leaving an Inpatient facility against medical advice.

33. Charges for equipment including, but not limited to, motorized wheelchairs or beds, that exceeds the patient's needs for every day living activities as defined by the Americans with Disabilities Act as amended from time to time, unless Medically Necessary by independent review and not primarily for personal convenience.

34. Charges for specialized computer equipment including, but not limited to, Braille keyboards and voice recognition software, unless determined to be Medically Necessary by independent review, and not primarily for personal convenience.

35. Charges for detoxification services or Outpatient therapy under court order or as condition of parole, unless prescribed by a Physician.

36. Charges for health care services to treat alcohol or drug co-dependency.

37. Charges for court-ordered examinations or treatment, except when Medically Necessary and as ordered by a Physician.

38. Charges for examinations and treatment conducted for the purpose of medical research.

39. Charges for Federal Aviation Administration (FAA) and Department of Transportation (DOT) Physicals. (FAA and DOT physicals are paid by the Employer sponsored program.)

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The following general exclusions and limitations apply to all Expenses Incurred under this Plan:

1. Charges for services rendered or started, or supplies furnished prior to the effective date of coverage under the Plan, or after coverage is terminated under the Plan, except as specifically provided for in the Plan provisions.

2. Charges which are caused by or arising out of war or act of war, (whether declared or undeclared), civil unrest, armed invasion or aggression, or caused during service in the armed forces of any country.

3. Charges to the extent that the Covered Person could have obtained payment, in whole or in part, if he or she had applied for coverage or obtained treatment under any federal, state or other governmental program or in a treatment facility operated by a government agency, except where required by law, such as for cases of medical emergencies or for coverage provided by Medicaid.

4. Charges by the Covered Person for all services and supplies resulting from any workers' compensation related Injury/Illness which occur in the course of employment for wage or profit, or in the course of any volunteer work when the organization, for whom the Covered Person is volunteering, has elected or is required by law to obtain coverage for such volunteer work under state or federal workers' compensation laws or other legislation, including Employees' compensation or liability laws of the United States (collectively called "Workers' Compensation"). This exclusion applies to all such services and supplies resulting from a workers' compensation related Injury /Illness even though:

   A. Coverage for the Covered Person under Workers' Compensation provides benefits for only a portion of the services Incurred;

   B. The Covered Person's employer/volunteer organization has failed to obtain such coverage required by law;

   C. The Covered Person waived his/her rights to such coverage or benefits;

   D. The Covered Person fails to file a claim within the filing period allowed by law for such benefits;

   E. The Covered Person fails to comply with any other provision of the law to obtain such coverage or benefits;

   F. The Covered Person is permitted to elect not to be covered by Workers' Compensation but failed to properly make such election effective; or

   G. The Covered Person is permitted to elect not to be covered by Workers' Compensation and has affirmatively made that election.

   This exclusion will not apply to household and domestic employment, employment not in the usual course of the trade, business, profession or occupation of the Covered Person or Employee, or employment of a Dependent member of an Employee's family for whom an exemption may be claimed by the Employee under the Internal Revenue Code, or in cases in which it is legally impossible to obtain Workers' Compensation coverage for a specific Illness or Injury.

5. Charges for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage. **This exclusion does not apply to involuntary detainment or commitment pursuant to Florida Statutes 394.451 (2009 Rev.) (known as the Baker Act).**

6. Charges for non-prescription vitamins or nutritional supplements, except as specifically covered under the Preventive Care Benefit.

7. Charges for services or supplies used primarily for cosmetic, personal comfort, convenience, beautification items, television or telephone use that are not related to treatment of a medical condition.

8. Charges for non-medical expenses such as training, education, instructions or educational materials, even if they are performed, provided or prescribed by a Physician, except as specifically listed as a covered expense.

9. Charges for Expenses Incurred by persons other than the Covered Person receiving treatment.

10. Charges in excess of the Eligible Expense.

11. Charges for services rendered by a Physician or Licensed Health Care Provider who is a Close Relative of the Covered Person, or resides in the same household of the Covered Person and who does not regularly charge the Covered Person for services.

12. Charges for professional services on an Outpatient basis in connection with disorders of any type or cause, that can be credited towards earning a degree or furtherance of the education or training of a Covered Person regardless of the diagnosis.

13. Charges for services, treatment or supplies not considered legal in the United States.

14. Charges for travel Expenses Incurred by any person for any reason, except as specifically covered under the Organ or Tissue Transplant Benefit.

15. Charges for services, treatments or supplies that may be useful to persons in the absence of Illness or Injury such as air conditioners, purifiers, humidifiers, special furniture, bicycles, whirlpools, dehumidifiers, exercise equipment, health club memberships, etc., whether or not they have been prescribed or recommended by a Physician.

16. Charges in connection with any operation or treatment for temporomandibular joint dysfunction or any related diagnosis or treatment of any nature including, but not limited to, correction of the position of the jaws in relation to each other (orthognathic surgery), realignment of the teeth or jaws, surgery for atrophy of the lower jaw, occlusion, maxillofacial surgery, or retrognathia. This includes Expenses Incurred for any appliance or prosthetic device used to replace tooth structure lost as a result of abrasion or attrition.

17. Charges for preparation of reports or itemized bills in connection with claims, unless specifically requested and approved by the Plan.

18. Charges for services or supplies that are not specifically listed as a covered benefit of this Plan.

19. Charges for any services or supplies to the extent that benefits are otherwise provided under this Plan, or under any other plan of group benefits that the Participant's Employer contributes to or sponsors.

20. Charges for incidental supplies or common first-aid supplies such as, but not limited to, adhesive tape, bandages, antiseptics, analgesics, etc.

21. Charges for the following treatments, services or supplies:

    A. Charges related to or connected with treatments, services or supplies that are excluded under this Plan.

    B. Charges that are the result of any medical complication resulting from a treatment, service or supply which is, or was at the time the charge was incurred, excluded from coverage under this Plan.

22. Charges for treatment, services or supplies not actually rendered to or received and used by the Covered Person.

23. Charges for broken or missed appointments.

24. Charges for services rendered by a Licensed Health Care Provider acting outside the scope of their training, certification or medical license.

COORDINATION OF BENEFITS

The Coordination of Benefits provision prevents the payment of benefits which exceed the Allowable Expense. It applies when the Participant or Dependent who is covered by this Plan is or may also be covered by any other plan(s). This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan(s), will not exceed 100% of the Allowable Expense. Only the amount paid by this Plan will be charged against the Plan maximums.

In the event of a motor vehicle or premises accident; or an act of violence with the intent to disrupt electronic, communications, or any other business system, this Plan will be secondary to any auto "no fault" and traditional auto "fault" type contracts, homeowners, commercial general liability insurance and any other medical benefits coverage.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization is hereby given this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

All benefits contained in the Plan Document are subject to this provision.

DEFINITIONS

"Allowable Expense" as used herein means:

1. If the claim as applied to the primary plan is subject to a contracted or negotiated rate, Allowable Expense will be equal to that contracted or negotiated amount.

2. If the claim as applied to the primary plan is not subject to a contracted or negotiated rate, but the claim as applied to the secondary plan is subject to a contracted or negotiated rate, the Allowable Expense will be equal to that contracted or negotiated amount of the secondary plan.

3. If the claim as applied to the primary plan and the secondary plan is not subject to a contracted or negotiated rate, then the Allowable Expense will be equal to the secondary plan's chosen limits for non-contracted providers.

"Plan" as used herein means any Plan providing benefits or services for or by reason of medical, dental or vision treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis including, but not limited to:

   A. Hospital indemnity benefits; and

   B. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of claims; or

2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans; or

3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision; or

4. A licensed Health Maintenance Organization (HMO); or

5. Any coverage for students which is sponsored by, or provided through a school or other educational institution; or

6. Any coverage under a governmental program, and any coverage required or provided by any statute; or

7. Automobile insurance; or

8. Individual automobile insurance coverage on an automobile leased or owned by the Employer or any responsible third-party tortfeasor; or

9. Individual automobile insurance coverage based upon the principles of "No-Fault" coverage; or

10. Homeowner or premise liability insurance, individual or commercial.

"Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

ORDER OF BENEFIT DETERMINATION

1. **Non-Dependent/Dependent:**

   The plan that covers the person as other than a dependent, (e.g., as an employee, member, subscriber, retiree) is primary and the plan that covers the person as a dependent is secondary.

2. **Dependent Child Covered Under More Than One Plan:**

   Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

   A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      1) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
      2) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

   B. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

      1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;
      2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph A of this paragraph shall determine the order of benefit;
      3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph A of this paragraph shall determine the order of benefit;

4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a) The plan covering the custodial parent;
b) The plan covering the custodial parent's spouse;
c) The plan covering the non-custodial parent; and then
d) The plan covering the non-custodial parent's spouse.

C. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a or b of this paragraph as if those individuals were parents of the child.

D. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph 5 applies.

E. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parent's plans, the order of benefits shall be determined by applying the birthday rule in subparagraph A to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-Off Employee**

A. The plan that covers a person as an active employee that is an employee who is neither laid-off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

B. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. This rule does not apply if the rule in paragraph 1 can determine the order of benefits.

4. **COBRA or State Continuation Coverage:**

A. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering the same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. This rule does not apply if the rule in paragraph 1 can determine the order of benefits.

5. **Longer or Shorter Length of Coverage**

A. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

B. To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.

C. The start of a new plan does not include:

1) A change in the amount or scope of a plan's benefits;
2) A change in the entity that pays, provides or administers the plan's benefits; or
3) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

D. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

6. If none of the preceding rules determines the order of benefits, the Allowable Expense shall be shared equally between the plans.

COORDINATION WITH MEDICARE

A Covered Person who is in the Employer's Early Retiree Incentive Program is not considered to be retired and is considered to be currently employed for purposes of receiving benefits under this Plan.

Medicare Part A and Part B will be considered a plan for the purposes of coordination of benefits. This Plan will coordinate benefits with Medicare whether or not the Covered Person is actually receiving Medicare benefits.

1. **For Working Aged**

A covered Employee who is eligible for Medicare Part A or Part B as a result of age may be covered under this Plan and be covered under Medicare, in which case this Plan will pay primary. A covered Employee, eligible for Medicare Part A or Part B as a result of age, may elect not to be covered under this Plan. If such election is made, coverage under this Plan will terminate.

A covered Dependent, eligible for Medicare Part A or Part B as a result of age, of a covered Employee may also be covered under this Plan and be covered under Medicare, in which case the Plan again will pay primary. A covered Dependent, eligible for Medicare Part A or Part B as a result of age, may elect not to be covered under this Plan. If such election is made, coverage under this Plan will terminate.

2. **For Retired Persons**

Medicare is primary and the Plan will be secondary for the covered Retiree if he/she is an individual who is enrolled in Medicare Part A or Part B as a result of age and retired.

Medicare is primary and the Plan will be secondary for the covered Retiree's Dependent who is enrolled in Medicare Part A or Part B if both the covered Retiree and his/her covered Dependent are enrolled in Medicare Part A or Part B as a result of age and retired.

Medicare is primary for the Retiree's Dependent when the Retiree is not enrolled for Medicare Part A or Part B as a result of age and the Retiree's Dependent is enrolled in Medicare Part A or Part B as a result of age.

3. **For Covered Persons who are Disabled**

The Plan is primary and Medicare will be secondary for the covered Employee or any covered Dependent who is eligible for Medicare by reason of disability, if the Employee is actively employed by the Employer.

The Plan is secondary and Medicare will be primary for the covered Employee or any covered Dependent who is eligible for Medicare by reason of disability if the Employee is retired or otherwise not actively working for the Employer.

4. **For Covered Persons with End Stage Renal Disease**

Except as stated below*, for Employees or Retirees and their Dependents, if Medicare eligibility is due solely to End Stage Renal Disease (ESRD), this Plan will be primary only during the first thirty (30) months of Medicare coverage. Thereafter, this Plan will be secondary with respect to Medicare coverage, unless after the thirty-month period described above, the Covered Person has no dialysis for a period of twelve (12) consecutive months and:

A. Then resumes dialysis, at which time the Plan will again become primary for a period of thirty (30) months; or

B. The Covered Person undergoes a kidney transplant, at which time the Plan will again become primary for a period of thirty (30) months.

*If a Covered Person is covered by Medicare as a result of disability, and Medicare is primary for that reason on the date the Covered Person becomes eligible for Medicare as a result of End Stage Renal Disease, Medicare will continue to be primary and the Plan will be secondary.

COORDINATION WITH MEDICAID

If a Covered Person is also entitled to and covered by Medicaid, the Plan will always be primary and Medicaid will always be secondary coverage.

COORDINATION WITH TRICARE/CHAMPVA

If a Covered Person is also entitled to and covered under TRICARE/CHAMPVA, the Plan will always be primary and TRICARE/CHAMPVA will always be secondary coverage. TRICARE coverage will include programs established under its authority, known as TRICARE Standard, TRICARE Extra and TRICARE Prime.

If the Covered Person is eligible for Medicare and entitled to veterans benefits through the Department of Veterans Affairs (VA), the Plan will always be primary and the VA will always be secondary for non-service connected medical claims. For these claims, the Plan will make payment to the VA as though the Plan was making payment secondary to Medicare.

PROCEDURES FOR CLAIMING BENEFITS

Claims must be submitted to the Plan within twelve (12) months after the date services or treatments are received or completed. Non-electronic claims may be submitted on any approved claim form, available from the provider. The claim must be completed in full with all the requested information. A complete claim must include the following information:

- Date of service;
- Name of the Participant;
- Name and date of birth of the patient receiving the treatment or service and his/her relationship to the Participant;
- Diagnosis [code] of the condition being treated;
- Treatment or service [code] performed;
- Amount charged by the provider for the treatment or service; and
- Sufficient documentation, in the sole determination of the Plan Administrator, to support the Medical Necessity of the treatment or service being provided and sufficient to enable the Third Party Administrator to adjudicate the claim pursuant to the terms and conditions of the Plan.

When completed, the claim must be sent to the Third Party Administrator, Allegiance Benefit Plan Management, Inc., at P.O. Box 3018, Missoula, Montana 59806-3018, (855) 333-1012 or through any electronic claims submission system or clearinghouse to which Allegiance Benefit Plan Management, Inc. has access.

A claim will not, under any circumstances, be considered for payment of benefits if initially submitted to the Plan more than twelve (12) months from the date that services were incurred.

Upon termination of the Plan, final claims must be received within three (3) months of the date of termination, unless otherwise established by the Plan Administrator.

Claims will not be deemed submitted until received by the third party administrator.

The Plan will have the right, in its sole discretion and at its own expense, to require a claimant to undergo a medical examination, when and as often as may be reasonable, and to require the claimant to submit, or cause to be submitted, any and all medical and other relevant records it deems necessary to properly adjudicate the claim.

CLAIM DECISIONS ON CLAIMS AND ELIGIBILITY

Claims will be considered for payment according to the Plan's terms and conditions, industry-standard claims processing guidelines and administrative practices not inconsistent with the terms of the Plan. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about claims that involve specialized medical knowledge or judgment. Initial eligibility and claims decisions will be made within the time periods stated below. For purposes of this section, "Covered Person" will include the claimant and the claimant's authorized representative; "Covered Person" does not include a health care provider or other assignee, and said health care provider or assignee does not have an independent right to appeal an Adverse Benefit Determination simply by virtue of the assignment of benefits.

"Authorized Representative" means a representative authorized by the claimant to act on their behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The claimant must authorize the representative in writing, and this written authorization must be provided to the Plan. The Plan will recognize this Authorized Representative when the Plan receives the written authorization.

Information regarding urgent care claims is provided under the disclosure requirements of applicable law; the Plan does not make treatment decisions. Any decision to receive treatment must be made between the patient and his or her healthcare provider; however, the Plan will only pay benefits according to the terms, conditions, limitations and exclusions of this Plan.

1. **Urgent Care Claims** - An Urgent Care Claim is any claim for medical care or treatment with respect to which:

   A. In the judgment of a prudent layperson possessing an average knowledge of health and medicine could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

   B. In the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

   There are no Urgent Care requirements under this Plan and therefore, there are no rights to appeal a pre-service Urgent Care claim denial.

2. **Pre-Service Claims** - Pre-Service Claims must be submitted to the Plan before the Covered Person receives medical treatment or service. A Pre-Service Claim is any claim for a medical benefit which the Plan terms condition the Covered Person's receipt of the benefit, in whole or in part, on approval of the benefit before obtaining treatment. Pre-Service Claims are procedures stated in the Plan Document which, the Plan recommends be utilized before a Covered Person obtains medical care.

3. **Post-Service Claims** - A Post-Service Claim is any claim for a medical benefit under the Plan with respect to which the terms of the Plan do not condition the Covered Person's receipt of the benefit, or any part thereof, on approval of the benefit prior to obtaining medical care, and for which medical treatment has been obtained prior to submission of the claim(s).

   In most cases, initial claims decisions on Post-Service Claims will be made within thirty (30) days of the Plan's receipt of the claim. The Plan will provide timely notice of the initial determination once sufficient information is received to make an initial determination, but no later than thirty (30) days after receiving the claim.

4. **Concurrent Care Review** - For patients who face early termination or reduction of benefits for a course of treatment previously certified by the Plan, a decision by the Plan to reduce or terminate benefits for ongoing care is considered an Adverse Benefit Determination. (Note: Exhaustion of the Plan's benefit maximums is not an Adverse Benefit Determination.) The Plan will notify the Covered Person sufficiently in advance to allow an appeal for uninterrupted continuing care before the benefit is reduced or terminated. Any request to extend an Urgent Care course of treatment beyond the initially prescribed period of time must be decided within twenty-four (24) hours of the Plan's receipt of the request. The appeal for ongoing care or treatment must be made to the Plan at least twenty-four (24) hours prior to the expiration of the initially-prescribed period.

APPEALING AN UN-REIMBURSED PRE-SERVICE CLAIM

If a claim is denied in whole or in part, the Covered Person will receive written notification of the Adverse Benefit Determination. A claim denial will be provided by the Plan showing:

1. The reason the claim was denied;

2. Reference(s) to the specific Plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;

3. Any additional information needed to perfect the claim and why such information is needed; and

4. An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review and the right to bring a civil action following an Adverse Benefit Determination on appeal.

If a Covered Person does not understand the reason for any Adverse Benefit Determination, he or she should contact the Third Party Administrator at the address or telephone number shown on the claim denial.

The Covered Person must appeal the Adverse Benefit Determination before the Covered Person may exercise his or her right to bring a civil action. This Plan provides two (2) levels of benefit determination review and the Covered Person must exercise both levels of review before bringing a civil action.

To initiate the first level of benefit review, the Covered Person must submit in writing an appeal or a request for review of the Adverse Benefit Determination to the Plan within one hundred eighty (180) days after the Adverse Benefit Determination. The Covered Person should include any additional information supporting the appeal or the information required by the Plan which was not initially provided and forward it to the Third Party Administrator within the 180-day time period. Failure to appeal the Adverse Benefit Determination within the 180-day time period will render the determination final. Any appeal received after the 180-day time period has expired will receive no further consideration.

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing to P.O. Box 1269, Missoula, MT 59806-1269. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

1. **First Level of Benefit Determination Review**

   The first level of benefit determination review is done by the Third Party Administrator. The Third Party Administrator will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within fifteen (15) days following the date the Third Party Administrator receives the request for reconsideration.

   If, based on the Third Party Administrator's review, the initial Adverse Benefit Determination remains the same and the Covered Person does not agree with that benefit determination, the Covered Person must initiate the second level of benefit review. The Covered Person must request the second review in writing and send it to the Third Party Administrator, not later than sixty (60) days after receipt of the Third Party Administrator's decision from the first level of review. Failure to initiate the second level of benefit review within the 60-day time period will render the determination final.

2. **Second Level of Benefit Determination Review**

   The second level review of the claim in question along with the additional information submitted by the Covered Person will be reviewed by the Appeals Committee of the Third Party Administrator (Appeals Committee). The Appeals Committee will conduct a full and fair review of the claim. The Appeals Committee will be neither the original decisionmaker nor the decisionmaker's subordinate. The Appeals Committee cannot give deference to the initial benefit determination. The Appeals Committee may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or Experimental or Investigational treatment, the Appeals Committee will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.

   After a full and fair review of the Covered Person's appeal, the Appeals Committee will provide a written or electronic notice of the final benefit determination, which contains the same information as notices for the initial determination, within fifteen (15) days.

If more time or information is needed to make a determination for a pre-service or post-service appeal, the Plan Supervisor will provide notice in writing to request an extension of up to fifteen (15) days and to specify any additional information needed to complete the review.

In the event any new or additional information is considered, relied upon or generated in connection with the appeal, the Plan will provide this information to the Covered Person as soon as possible, free of charge and sufficiently in advance of the decision, so that the Covered Person will have an opportunity to respond. Also, if any new or additional rationale is considered for a denial it will be provided to the Covered Person as soon as possible and sufficiently in advance of the decision to allow a reasonable opportunity to respond.

If an appeal decision is not made and issued within the time period described above, or if the Plan fails to meet any of the requirements of this appeal process, the Covered Person may deem the appeal to be exhausted and proceed to the external review or bring a civil action. The Covered Person should contact the Plan Administrator to ask for confirmation that the Covered Person's appeal has been denied, or to request an External Review.

INDEPENDENT EXTERNAL REVIEW FOR A PRE-SERVICE CLAIM

After exhaustion of all appeal rights stated above, a Covered Person may also request a final independent external review of any Adverse Benefit Determination involving a question of Medical Necessity, or other issue requiring medical expertise for resolution.

To assert this right to independent external medical review, the Covered Person must request such review in writing within one hundred twenty (120) days after a decision is made upon the second level benefit determination above.

If an independent external review is requested, the Plan Supervisor will forward the entire record on appeal, within ten (10) days, to an independent external review organization (IRO) selected randomly. The IRO will notify the Covered Person of its procedures to submit further information.

The IRO will issue a final decision within forty-five (45) days after receipt of all necessary information.

The decision of the IRO will be final and binding except that the Covered Person shall have an additional right to appeal the matter to a court with jurisdiction.

APPEALING AN UN-REIMBURSED POST-SERVICE CLAIM

If a claim is denied in whole or in part, the Covered Person will receive written notification of the Adverse Benefit Determination. A claim Explanation of Benefits (EOB) will be provided by the Plan showing:

1. The reason the claim was denied;

2. Reference(s) to the specific Plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;

3. Any additional information needed to perfect the claim and why such information is needed; and

4. An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review and the right to bring a civil action following an Adverse Benefit Determination on appeal.

If a Covered Person does not understand the reason for any Adverse Benefit Determination, he or she should contact the Third Party Administrator at the address or telephone number shown on the EOB form.

The Covered Person must appeal the Adverse Benefit Determination before the Covered Person may exercise his or her right to bring a civil action. This Plan provides two (2) levels of benefit determination review and the Covered Person must exercise both levels of review before bringing a civil action.

To initiate the first level of benefit review, the Covered Person must submit in writing an appeal or a request for review of the Adverse Benefit Determination to the Plan within one hundred eighty (180) days after the Adverse Benefit Determination. The Covered Person should include any additional information supporting the appeal or the information required by the Plan which was not initially provided and forward it to the Third Party Administrator within the 180-day time period. Failure to appeal the Adverse Benefit Determination within the 180-day time period will render the determination final. Any appeal received after the 180-day time period has expired will receive no further consideration.

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing to P.O. Box 1269, Missoula, MT 59806-1269. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

1. **First Level of Benefit Determination Review**

   The first level of benefit determination review is done by the Third Party Administrator. The Third Party Administrator will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within thirty (30) days following the date the Third Party Administrator receives the request for reconsideration.

   If, based on the Third Party Administrator's review, the initial Adverse Benefit Determination remains the same and the Covered Person does not agree with that benefit determination, the Covered Person must initiate the second level of benefit review. The Covered Person must request the second review in writing and send it to the Third Party Administrator, not later than sixty (60) days after receipt of the Third Party Administrator's decision from the first level of review. Failure to initiate the second level of benefit review within the 60-day time period will render the determination final.

2. **Second Level of Benefit Determination Review**

   The second level review of the claim in question along with the additional information submitted by the Covered Person will be reviewed by the Appeals Committee of the Third Party Administrator (Appeals Committee). The Appeals Committee will conduct a full and fair review of the claim. The Appeals Committee will be neither the original decisionmaker nor the decisionmaker's subordinate. The Appeals Committee cannot give deference to the initial benefit determination. The Appeals Committee may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or Experimental or Investigational treatment, the Appeals Committee will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.

   After a full and fair review of the Covered Person's appeal, the Appeals Committee will provide a written or electronic notice of the final benefit determination within a reasonable time, but no later than thirty (30) days from the date the appeal is received by the Plan at each level of review.

All claim payments are based upon the terms contained in the Plan Document, on file with the Plan Administrator and the Third Party Administrator. The Covered Person may request, free of charge, more detailed information, names of any medical professionals consulted and copies of relevant documents, as defined in and required by law, which were used by the Plan to adjudicate the claim.

If more time or information is needed to make a determination for a pre-service or post-service appeal, the Plan Supervisor will provide notice in writing to request an extension of up to fifteen (15) days and to specify any additional information needed to complete the review.

In the event any new or additional information is considered, relied upon or generated in connection with the appeal, the Plan will provide this information to the Covered Person as soon as possible, free of charge and sufficiently in advance of the decision, so that the Covered Person will have an opportunity to respond. Also, if any new or additional rationale is considered for a denial it will be provided to the Covered Person as soon as possible and sufficiently in advance of the decision to allow a reasonable opportunity to respond.

If an appeal decision is not made and issued within the time period described above, or if the Plan fails to meet any of the requirements of this appeal process, the Covered Person may deem the appeal to be exhausted and proceed to the external review or bring a civil action. The Covered Person should contact the Plan Administrator to ask for confirmation that the Covered Person's appeal has been denied, or to request an External Review.

INDEPENDENT EXTERNAL REVIEW FOR A POST-SERVICE CLAIM

After exhaustion of all appeal rights stated above, a Covered Person may also request a final independent external review of any Adverse Benefit Determination involving a question of Medical Necessity, or other issue requiring medical expertise for resolution.

To assert this right to independent external medical review, the Covered Person must request such review in writing within one hundred twenty (120) days after a decision is made upon the second level benefit determination above.

If an independent external review is requested, the Third Party Administrator will forward the entire record on appeal, within ten (10) days, to an independent external review organization (IRO) selected randomly. The IRO will notify the Covered Person of its procedures to submit further information.

The IRO will issue a final decision within forty-five (45) days after receipt of all necessary information.

The decision of the IRO will be final and binding except that the Covered Person shall have an additional right to appeal the matter to a court with jurisdiction.

ELIGIBILITY PROVISIONS

If both spouses are employed by the Employer, and both are eligible for Dependent Coverage, either spouse, but not both, may elect Dependent Coverage for their eligible Dependents. No one can be covered under this Plan as both an Employee and a Dependent. No one can be covered under this Plan as a Dependent by more than one Participant.

EMPLOYEE ELIGIBILITY

An eligible Employee under this Plan includes only a person who is any of the following classifications:

1. Class 1 - Collier County Education Association (CCEA) and Non-Bargaining Unit Employee who is either a:

   A. Full-time or part-time Employee regularly scheduled to work a minimum of 28.125 hours per week (.50 FTE - .75 FTE), which shall include all hours worked for the Employer in any capacity.

   B. Part-time grandfathered Employee regularly scheduled to work a minimum of 18.75 hours per week (eligible to purchase healthcare coverage and other benefits) and who was hired or reassigned before October 15, 2009, which shall include all hours worked for the Employer in any capacity.

2. Class 2 - Collier County Association of Educational Office & Classroom Assistant Personnel (CCAEOCAP) Employee who is either a:

   A. Full-time or part-time Employee regularly scheduled to work a minimum of thirty (30) hours per week, which shall include all hours worked for the Employer in any capacity.

   B. Part-time grandfathered Employee regularly scheduled to work a minimum of twenty (20) hours per week (eligible to purchase healthcare coverage and other benefits) and who was hired or reassigned before October 15, 2009, which shall include all hours worked for the Employer in any capacity.

3. Class 3 - Teamsters Employee who is either:

   A. Full-time or part-time Employee regularly scheduled to work a minimum of thirty (30) hours per week, except for bus drivers and attendants, which shall include all hours worked for the Employer in any capacity.

   B. Full-time or part-time bus drivers and attendants regularly scheduled to work a minimum of twenty-five (25) hours per week, which shall include all hours worked for the Employer in any capacity.

4. Class 4 - Is employed as a variable hour Employee, defined as any Employee that is not a Class 1, Class 2 or Class 3 Employee, and completes a Measurement Period of twelve (12) consecutive months, during which the variable hour Employee averages one hundred thirty (130) hours per month of actual work and/or paid leave, FMLA leave or jury duty whether paid or not, for or through the Employer in any capacity for twelve (12) consecutive months.

   "Measurement Period" is the period of time adopted by the Plan for variable hour Employees during which such Employees' work hours and paid leave are measured to determine whether such Employees are eligible for coverage.

An Employee is not eligible while on active duty if that duty exceeds a period of thirty-one (31) consecutive days.

As a requirement for enrollment under this Plan, all eligible Dependents of Participants will be required to provide their social security number to the Plan Administrator. This is necessary for the Plan Administrator to comply with any and all reporting requirements imposed under federal CMS (Medicare) guidelines.

WAITING PERIOD

With respect to an eligible Class 1, 2, 3 or 4 Employee, the Waiting Period is waived and coverage begins on the contract day as defined in the eligibility criteria above (Enrollment Date).

With respect to an eligible Dependent of an eligible Employee, coverage under the Plan will not start until the Dependent completes a Waiting Period. The Plan's Waiting Period for an eligible Dependent is the period of time commencing on the contract day as defined in the eligibility criteria above for the related Employee (Enrollment Date) and ends on the last day of the month following the Enrollment Date.

DEPENDENT ELIGIBILITY

An eligible Dependent includes any person who is a citizen, resident alien, or is otherwise legally present in the United States or in any other jurisdiction that the related Participant has been assigned by the Employer, and who is either:

1. The Participant's legal spouse according to the marriage laws of the state where the marriage was first solemnized or established or established and for which a marriage license or similar document was issued by the appropriate civil authority in such state. The Plan Administrator shall have the right, in its sole discretion, to require proof of such marriage.

   An eligible Dependent does not include a spouse who is legally separated or divorced from the Participant and has a court order or decree stating such from a court of competent jurisdiction.

2. The Participant's Dependent child pursuant to Federal Health Care Reform who meets all of the following "Required Eligibility Conditions":

   A. Is a natural child; step-child; legally adopted child; a child who has been Placed for Adoption with the Participant and for whom as part of such placement the Participant has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement; a person for whom the Participant has been appointed the legal guardian by a court of competent jurisdiction prior to the person attaining nineteen (19) years of age; and

   B. Is less than twenty-six (26) years of age. This requirement is waived if the Participant's child is mentally handicapped/challenged or physically handicapped/challenged, provided that the child is incapable of self-supporting employment and is chiefly dependent upon the Participant for support and maintenance. Proof of incapacity must be furnished to the Plan Administrator upon request, and additional proof may be required from time to time.

   An eligible Dependent does not include a spouse of the Dependent child or a child of the Dependent child.

EXTENDED COVERAGE FOR DEPENDENTS

An Extended-Coverage Child as defined by Florida Statute 627.6562 who is twenty-six (26) years of age but less than thirty (30) years of age may continue to be an eligible Dependent if the Dependent child was covered under this Plan on the last day of the Calendar Year after the Dependent child attains twenty-six (26) years of age and meets all of the following criteria required by Florida Statute:

1. Unmarried without Dependents of their own; and

2. A Florida resident or a full or part-time student; and

3. Not provided coverage under any other health plan or policy; and

4. Not entitled to coverage under Medicare.

The eligible Employee must make an election to continue coverage for the Extended-Coverage Child, and file an Affidavit of Dependent Eligibility, within thirty-one (31) days following the date such child ceases to satisfy the eligibility requirements for eligible Dependent coverage under the Plan. Such Extended-Coverage Child may continue coverage until the last day of the Calendar Year in which the Extended-Coverage Child attains the age of thirty (30) years of age.

If an eligible Employee fails to make an election to continue coverage under this provision within the time frame or if coverage under this provision terminates, the child will be eligible to make an election to continue coverage in accordance with the COBRA Continuation Coverage section of this Plan.

The eligible Employee or Extended-Coverage Child is required to pay the entire amount of the cost of coverage for the Extended-Coverage Child under this provision in accordance with the same procedures established under the COBRA Continuation Coverage section of this Plan.

PARTICIPANT ELIGIBILITY FOR DEPENDENT COVERAGE

Each Employee will become eligible for Dependent Coverage on the latest of:

1. The date the Employee becomes eligible for Participant coverage; or

2. The first day of the month in which the Employee first acquires a Dependent.

RETIREE ELIGIBILITY

A qualifying Retiree of The District School Board of Collier County, is considered eligible for coverage under this Plan if the requirements of the Florida Statutes 121.091, 121.091 and 112.0801(2) for Normal, Early or Disability retirement are met. For a qualifying Retiree, and any eligible Dependent of the Retiree, coverage begins on the first day of the month following retirement in accordance with F.S. 112.0801 provided all enrollment requirements have been met.

Retirees and their eligible Dependents may remain on the Plan indefinitely as long as premiums are current and made in a timely manner. Failure to make any premium payment will terminate coverage. Coverage may not be confirmed until the premium is actually received by the Third Party Administrator.

Eligible Dependents of a qualifying Retiree who are not covered immediately before the date of retirement are eligible for coverage under this Plan and may be enrolled upon retirement or during any Open Enrollment Period.

Should a Retiree elect to discontinue coverage upon becoming eligible for Medicare, his or her Dependent spouse may continue coverage under this Plan by payment of the full premium cost for a single Retiree, until such time as he or she is eligible for Medicare or is eligible for coverage under another plan. Such Dependent spouse may not continue coverage under this Plan if the Retiree elects to discontinue his or her own coverage for any reason other than Medicare eligibility.

Dependent spouses of deceased Retirees, who have been covered as a Dependent spouse, may continue the coverage until eligible for Medicare.

PLEASE NOTE: If Retiree becomes reemployed by the District School Board of Collier County he/she will no longer be eligible to participate in the District's health insurance plan if and when he/she returns to retirement status. These provisions shall take effect on January 1, 2020 and apply to any Retiree rehired on or after January 1, 2020.

ELIGIBILITY UNDER SPECIAL PROVISIONS

Per special provisions or employment agreements, an individual and their Dependents, may be provided extended coverage until eligible for Medicare.

EFFECTIVE DATE OF COVERAGE

All coverage under the Plan will commence at 12:01 A.M. in the time zone in which the Covered Person permanently resides, on the date such coverage becomes effective.

PARTICIPANT COVERAGE

Participant coverage under the Plan will become effective on the Enrollment Date, provided that application for coverage is made on the Plan's enrollment electronic or paper form within thirty (30) days following the Enrollment Date. If these requirements are met, the Employee must be offered coverage or an opportunity to waive coverage even if the offer is after the date coverage should become effective, regardless of the time that has elapsed, provided that the reason coverage was not offered before the end of the Waiting Period was as a result of an administrative error on the part of the Employer, Plan Administrator or Third Party Administrator.

If an Employee is absent from work on the date coverage will become effective other than for reasons due to a health factor, coverage for the Employee and his or her Dependents will be delayed until the date on which the Employee returns to work and completes one (1) full day of employment.

An eligible Employee who declines Participant coverage under the Plan will be able to become covered later in only two situations, Open Enrollment Period and Special Enrollment Period.

A variable hour Employee will remain covered for a period of time not to exceed twelve (12) months from the effective date of coverage (the Coverage Period) regardless of the number of hours worked and applicable leave, as long as the individual remains employed by the Employer. At the end of the Coverage Period, if the individual remains employed as a variable hour Employee and averages at least one hundred thirty (130) hours per month during the Coverage Period, the individual will remain covered for a period of time not to exceed an additional twelve (12) months.

"Coverage Period" is the maximum period of time variable hour Employees can be covered under the Plan as active Employees after completion of a Measurement Period as defined in the "Eligibility Provisions" under the "Employee Eligibility" subsection.

If an eligible Employee chooses not to enroll or fails to enroll for coverage under the Plan during the Initial Enrollment Period, coverage for the Employee and Dependents will be deemed waived.

If a Participant chooses not to re-enroll or fails to re-enroll during any Open Enrollment Period, coverage for the Participant and any Dependents covered at the time will remain the same as that elected prior to the Open Enrollment Period.

DEPENDENT COVERAGE

Each Participant who requests Dependent Coverage for an eligible Dependent will be enrolled for Dependent Coverage as follows:

1. On the first day of the month following the Participant's effective date of coverage, if enrolled at the same time as the Participant. This subsection applies only to Dependents who are eligible on the Participant's effective date of coverage.

2. In the event a Dependent is acquired after the Participant's effective date of coverage as a result of a legal guardianship or in the event that a Participant is required to provide coverage as a result of a valid court order, or if the Dependent is acquired as a result of operation of law, Dependent Coverage will begin on the first day of the month following the Plan's receipt of a copy of said court order, if applicable.

RETIREE COVERAGE

Coverage for a qualifying Retiree, and any eligible Dependent of the Retiree, begins on the first day of the month following retirement, provided all applicable enrollment requirements have been met.

ENROLLMENT REQUIREMENTS

To enroll for coverage under this Plan the following procedures apply and are required:

1. Newly hired Employees must enroll during specified dates and times which are communicated at the New Hire Meetings. Enrollment information is also available on The District School Board of Collier County Benefits and Wellness website at: http://www.collierschools.com/Page/7980.

2. Current Participants who wish to make midyear enrollment changes must contact The District School Board of Collier County Benefits and Wellness Office at (239) 377-0340 or benefits@collierschools.com.

3. For the annual Open Enrollment Period, Employees may make changes using the Plan's online enrollment system or they may meet with an enroller either face-to-face or by telephone.

PERMISSIBLE ENROLLMENT RIGHTS

For the sake of this Plan Document/Summary Plan Description, Open Enrollment Period and Special Enrollment Period shall be understood to be permissible enrollment events as more fully discussed in Permissible Enrollment Changes.

OPEN ENROLLMENT PERIOD

The Open Enrollment Period will be as determined by the Plan Administrator, during which Participants are able to elect a different level of coverage and change the Dependents covered under the Plan. An Employee and the Employee's eligible Dependents must request Participant or Dependent coverage as outlined by the Plan Administrator.

Coverage or changes in Plan Options requested during the Open Enrollment Period will be effective at the beginning of the Plan Year and will remain in effect through the end of the Plan Year, except as allowed during any Special Enrollment Period or mid-year change.

Employees who do not make an election during the Open Enrollment Period will be deemed to have elected to continue their present coverage and will automatically be enrolled in the same coverage for the upcoming Benefit Period.

SPECIAL ENROLLMENT PERIOD

In addition to other enrollment times allowed by this Plan, certain persons may enroll during the Special Enrollment Periods described below.

"Special Enrollment Period" means a period of time allowed under this Plan, other than the eligible person's Initial Enrollment Period or an Open Enrollment Period, during which an eligible person can request coverage under this Plan as a result of certain events that create special enrollment rights.

Coverage will become effective on the date of the event if the Employee makes a special enrollment request, verbally or in writing, within thirty (30) days of any special enrollment event.

1. An eligible Employee who is not enrolled and eligible Dependents, including step children, who are acquired under the following specific events may enroll and become covered:

    A. Marriage to the Employee; or

    B. Birth of the Employee's child; or

    C. Adoption of a child by the Employee, provided the child is under the age of 19; or

    D. Placement for Adoption with the Employee, provided such Employee has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.

2. A Participant may enroll eligible Dependents, including step children, who are acquired under the following specific events:

    A. Marriage to the Participant; or

    B. Birth of the Participant's child; or

    C. Adoption of a child by the Participant, provided the child is under the age of 19; or

    D. Placement for Adoption with the Employee, provided such Employee has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.

3. The spouse of a Participant (Covered Employee), may enroll and will become covered on the date of the following specific events:

    A. Marriage to the Participant; or

    B. Birth of the Participant's child; or

    C. Adoption of a child by the Participant, provided the child is under the age of 19; or

    D. Placement for Adoption with the Employee, provided such Employee has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.

4. The following individuals may enroll and become covered when coverage under another health care plan or health insurance is terminated due to loss of eligibility or if employer contributions to the other coverage have been terminated (Loss of Coverage), subject to the following:

    A. If the eligible Employee loses coverage, the eligible Employee who lost coverage and any eligible Dependents of the eligible Employee may enroll and become covered.

    B. If an eligible Dependent loses coverage, the eligible Dependent who lost coverage and the eligible Employee may enroll and become covered.

Further, Loss of Coverage means only one of the following:

A. COBRA Continuation Coverage under another plan and the maximum period of COBRA Continuation Coverage under that other plan has been exhausted; or

B. Group or insurance health coverage that has been terminated as a result of termination of Employer contributions* towards that other coverage; or

C. Group or insurance health coverage (includes other coverage that is Medicare) that has been terminated only as a result of a loss of eligibility for coverage for any of the following:

1) Legal separation or divorce of the eligible Employee;
2) Cessation of Dependent status;
3) Death of the eligible Employee;
4) Termination of employment of the eligible Dependent;
5) Reduction in the number of hours of employment of the eligible Dependent;
6) Termination of the eligible Dependent's employer's plan; or
7) Any loss of eligibility after a period that is measured by reference to any of the foregoing; or
8) Any loss of eligibility for individual or group coverage because the eligible Employee or Dependent no longer resides, lives or works in the service area of the Health Maintenance Organization (HMO) or other such plan.

*Employer contributions include contributions by any current or former employer that was contributing to the other non-COBRA coverage.

A loss of eligibility for coverage does not occur if coverage was terminated due to a failure of the Employee or Dependent to pay premiums on a timely basis or coverage was terminated for cause.

5. Individuals may enroll and become covered when coverage under Medicaid or any state children's insurance program recognized under the Children's Health Insurance Program Reauthorization Act of 2009 is terminated due to loss of eligibility, subject to the following:

A. A request for enrollment must be made either verbally or in writing within sixty (60) days after this special enrollment event, and written application for such coverage must be made within ninety (90) days after such event.

B. If the eligible Employee loses coverage, the eligible Employee who lost coverage and any eligible Dependents of the eligible Employee may enroll and become covered.

C. If an eligible Dependent loses coverage, the eligible Dependent who lost coverage and the eligible Employee may enroll and become covered.

6. Individuals who are eligible for coverage under this Plan may enroll and become covered on the date they become entitled to a Premium Assistance Subsidy authorized under the Children's Health Insurance Program Reauthorization Act of 2009. The date of entitlement shall be the date stated in the Premium Assistance Authorization entitlement notice issued by the applicable state agency (CHIP or Medicaid). A request for enrollment, either verbal or in writing, must be made within sixty (60) days after this special enrollment event, and written application for such coverage must be made in writing within ninety (90) days after such event.

For any Special Enrollment event, the Participant may also elect to change coverage options to any coverage option offered by the Plan. The Coverage Option for the Dependent must be the same as the Participant.

PERMISSIBLE ENROLLMENT CHANGES

An Employee may not make enrollment changes in any way during the Benefit Period except in the case of a Special Enrollment right or the following certain limited circumstances:

1. An Employee may enroll Dependents during a Benefit Period if one of the following changes in status events occurs that results in a gain or loss of eligibility for coverage:

    A. A Change in the Employee's legal marital status.

    B. A change in the Employees number of Dependents.

    C. A change in the employment status (such as termination of employment, a strike or lockout, a commencement or return from an unpaid leave of absence or change in work site) of the Employee or the Employee's Dependent spouse or children which affects his or her eligibility to participate in the Plan or other employee benefit plan of an Employer.

    D. A Dependent of the Employee either newly satisfies or ceases to satisfy the eligibility requirements of the Plan.

    E. A change in the legal residence of an Employee, the Employee's Dependent spouse or children which affects his or her eligibility to participate in the Plan.

    F. An order by a court or state child support agency resulting from a divorce, legal separation, annulment or change in custody that requires the Employee to provide health coverage to an Employee's eligible child.

2. An Employee may also be permitted to enroll for coverage due to the following:

    A. A significant increase or decrease in the cost charged to the Employee under the Plan.

    B. A significant curtailment of coverage under the Plan.

    C. The addition or significant improvement of a medical coverage option under the Plan.

    D. The Employee's Dependent spouse or children has a change in coverage under his or her own employer's plan.

    E. The Employee's Dependent experiences a change in eligibility under Medicare, Medicaid or Florida KidCare.

Any requested enrollment change must be on account of and consistent with the change in status. Documentation will be required on all Dependents.

The Employee must change his or her election within thirty (30) days of the event that permits the enrollment change. Any modification or revocation under this shall be effective at such time as the Plan Administrator shall prescribe, but not earlier than the first pay period beginning after the election is submitted to the Plan Administrator. Once the election is submitted, any modification relating to the coverage of additional family members shall be effective retroactively to the date the change in family status occurred.

The Plan Administrator has the discretionary authority to make a determination as to whether an event has occurred permitting a change during the Benefit Period and whether the requested change is on account of and consistent with the rules and regulations of the Internal Revenue Service.

In accordance with the Affordable Care Act's (PPACA) anti-rescission rule, in the absence of lapse of premium, fraud or intentional misrepresentation, retroactive termination of benefits is not allowed. Terminating a Dependent from coverage can only be done prospectively, not retroactively.

Dependent coverage terminates at the end of the month in which the Dependent exercises a change in coverage (i.e., Medicare/Medicaid eligibility, eligibility under their employer's plan or a spouse's plan, termination of coverage per court order, etc.) provided the event allowing a change in coverage occurs within thirty (30) days prior to the date a change in coverage is requested. In the event the Employee does not receive notice of a Permissible Enrollment Event until more than thirty (30) days after such an event, through circumstances beyond the Employee's and Dependent's control, the Dependent may be added or terminated from coverage as applicable at the end of the month in which the Employee received notice if the Employee requests enrollment or termination within thirty (30) days after receipt of such notice. Further, Dependent coverage can be terminated under this section on the date the Permissible Enrollment Event occurs if no premium has been paid for the period after the date of the Permissible Enrollment Event.

Written notice of the Permissible Enrollment Event and supporting documentation must be received by the Third Party Administrator within thirty (30) days after the Permissible Enrollment Event date or within thirty (30) days after the date of late notice, whichever is applicable. If notice and documentation is received after the end of the month in which the Permissible Enrollment Event occurs, but within the thirty (30) days, the termination date will be the end of the month in which the Permissible Enrollment Event occurred.

Premiums cannot be refunded unless it is within the thirty (30) day time frame.

CHANGE IN EMPLOYMENT STATUS

If a Covered Dependent under this Plan becomes an eligible Employee of the Employer, he/she must elect to be covered as a Participant.

If an eligible Employee who is covered as a Participant of this Plan ceases to be an Employee of the Employer, but is eligible to be covered as a Dependent under another Employee/Participant, he/she may elect to continue his/her coverage as a Dependent of such Employee/Participant.

Application for coverage due to a Change in Status must be made within thirty (30) days immediately following the date the Employee becomes or ceases to be an eligible Employee. A Change in Status will not be deemed to be a break or termination of coverage and will not operate to reduce or increase any coverage or accumulations toward satisfaction of the deductible and Out-of-Pocket Maximum to which the Covered Person was entitled prior to the Change in Status.

CONTINGENT CONTRACTED SUBSTITUTE (GUEST) TEACHER EFFECTIVE DATE OF COVERAGE

For Employees who are initially hired as substitute (guest) teachers, as defined by Florida state law, until confirmation of degree conferred:

1. The effective date for Employee coverage will be the same as the contracted date (date degree conferred as listed on college transcript).

2. The effective date for Dependent coverage will be the first of the month following the date the transcript (confirming the degree conferred) is received in Human Resources, unless it exceeds ninety (90) days. If time frame exceeds ninety (90) days, the Dependent coverage will be effective the ninetieth (90^{th}) day after the degree was conferred.

QUALIFIED MEDICAL CHILD SUPPORT ORDER PROVISION

PURPOSE

The Plan Administrator adopts the following procedures to determine whether Medical Child Support Orders are qualified to administer payments and other provisions under Qualified Medical Child Support Orders (QMCSOs), and to enforce these procedures as legally required.

DEFINITIONS

For QMCSO requirements, the following definitions apply:

1. "Alternate Recipient" means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enroll in this Plan with respect to the Participant.

2. "Medical Child Support Order" means any state or court judgment, decree or order (including approval of settlement agreement) issued by a court of competent jurisdiction, or issued through an administrative process established under State law and which has the same force and effect of law under applicable State law and:

   A. Provides for child support for a child of a Participant under this Plan; or

   B. Provides for health coverage for such a child under state domestic relations laws (including community property laws) and relates to benefits under this Plan; and

   C. Is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act.

3. "Plan" means this self-funded Employee Health Benefit Plan, including all supplements and amendments in effect.

4. "Qualified Medical Child Support Order" means a Medical Child Support Order which creates (including assignment of rights) or recognizes an Alternate Recipient's right to receive benefits to which a Participant or Qualified Beneficiary is eligible under this Plan, and has been determined by the Plan Administrator to meet the qualification requirements as outlined under "Procedures" of this provision.

CRITERIA FOR A QUALIFIED MEDICAL CHILD SUPPORT ORDER

To be qualified, a Medical Child Support Order must clearly:

1. Specify the name and the last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient; and

2. Include 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; and

3. Specify each period to which such order applies.

In order to be qualified, a Medical Child Support Order must not require the Plan to provide any type or form of benefits, or any option, not otherwise provided under the Plan except to the extent necessary to meet the requirements of Section1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

PROCEDURES FOR NOTIFICATIONS AND DETERMINATIONS

In the case of any Medical Child Support Order received by this Plan:

1. The Plan Administrator will promptly notify the Participant and each Alternate Recipient of the receipt of such order and the Plan's procedures for determining whether Medical Child Support Orders are qualified orders; and

2. Within a reasonable period after receipt of such order, the Plan Administrator will determine whether such order is a Qualified Medical Child Support Order and notify the Participant and each Alternate Recipient of such determination.

NATIONAL MEDICAL SUPPORT NOTICE

If the Plan Administrator of a group health plan which is maintained by the Employer of a non-custodial parent of a child, or to which such an employer contributes, receives an appropriately completed National Medical Support Notice as described in Section 401(b) of the Child Support Performance and Incentive Act of 1998 in the case of such child, and the Notice meets the criteria shown above for a qualified order, the Notice will be deemed to be a Qualified Medical Child Support Order in the case of such child.

FAMILY AND MEDICAL LEAVE ACT OF 1993

For information regarding Family Medical Leave Act please refer to www.neola.com/collier-fl/

TERMINATION OF COVERAGE

PARTICIPANT TERMINATION

Participant coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month in which the Participant's employment terminates; or

2. On the last day of the month in which the Participant ceases to be eligible for coverage; or

3. The date the Participant fails to make any required contribution for coverage; or

4. The date the Plan is terminated; or

5. The date the Employer terminates the Participant's coverage; or

6. The date the Participant dies; or

7. On the last day of the month in which the Plan receives the Plan's Health Coverage Waiver Form for the Participant; or

8. For variable hour Employees on the last day of the Coverage Period, unless at the expiration of the Coverage Period, the Participant is otherwise eligible as the result of a subsequent Measurement Period or as a result of being reclassified as a Full Time Employee; or

9. For those Employees whose contracts end in May/June, coverage will terminate July 31st of the contract year in which the Participant does not return to Active Service in the fall and has not provided notice of separation until July or August.

A Participant whose Active Service ceases because of Illness or Injury or as a result of any other approved leave of absence may remain covered as an Employee in Active Service for a period of twelve (12) weeks, or such other length of time that is consistent with and stated in the School Board Policy and Collective Bargaining Agreement or pursuant to the Family and Medical Leave Act. Coverage under this provision will be subject to all the provisions of FMLA if the leave is classified as FMLA leave.

A Participant whose Active Service ceases due to temporary layoff will be considered employed by the Employer for the purposes of his/her coverage under this Plan, and such coverage may continue until the end of the month in which the layoff began.

If a Participant's coverage is to be continued during disability, approved leave of absence or temporary layoff, the amount of his or her coverage will be the same as the Plan benefits in force for an active Employee, subject to the Plan's right to amend coverage and benefits.

RETIREE TERMINATION

Retiree coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month in which the Retiree ceases to be eligible for coverage; or

2. The date the Retiree fails to make any required contribution for coverage; or

3. The date the Plan is terminated; or

4. The date the Employer terminates the Retiree's coverage; or

5. The date the Retiree dies.

DEPENDENT TERMINATION

Each Covered Person, whether Participant or Dependent, is responsible for notifying the Plan Administrator, within sixty (60) days after loss of Dependent status due to death, divorce, legal separation or ceasing to be an eligible Dependent child. Failure to provide this notice may result in loss of eligibility for COBRA Continuation Coverage After Termination.

Coverage for a Dependent will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month in which the Dependent ceases to be an eligible Dependent as defined in the Plan; or

2. On the last day of the month in which the Participant's coverage terminates under the Plan; or

3. On the last day of the month in which the Participant ceases to be eligible for Dependent Coverage; or

4. The date the Participant fails to make any required contribution for Dependent Coverage; or

5. The date the Plan is terminated; or

6. The date the Employer terminates the Dependent's coverage; or

7. On the last day of the month in which the Participant dies; or

8. On the last day of the month in which the Plan receives the Plan’s Health Coverage Waiver Form for the Dependent whose coverage is to be terminated.

REINSTATEMENT OF COVERAGE

Coverage must be reinstated as required by law under FMLA, USERRA or any similar law. In addition, the Plan Administrator has the discretionary authority to reinstate coverage for an Employee whose coverage terminates as follows:

1. Employee who returns to work following a non FMLA leave of absence. Coverage will be reinstated for the Employee on the date of renewed eligibility. The Employee may also change coverage options or add or drop covered Dependents. Application for such change in coverage or change of covered Dependents must be made within thirty (30) days after the date of renewed eligibility.

2. Employee who is recalled or rehired within one (1) year of their position being eliminated due to a reduction in force (RIF). Coverage will be reinstated on the date of renewed eligibility for the Employee and any eligible Dependents. Application for such coverage must be made within thirty (30) days after the date of renewed eligibility.

3. Retiree who continues coverage as a Retiree and returns to active employment. Active coverage will be effective on the first day of the month following the date of renewed eligibility for the Employee and eligible Dependents (Employee-paid). Application for such coverage must be made within thirty (30) days after the date of renewed eligibility.

4. For any Employee or former Employee for whom as a result of a binding legal or bargaining process the Employer is required to reinstate benefits retroactively, coverage for that Employee and all eligible Dependents will be effective on the date required by the legal or bargaining process.

Reinstatement of Coverage is subject to the following:

1. Credit will be given for prior amounts applied toward the Deductible and Out-of-Pocket Maximum for the same Benefit Period during which renewed eligibility occurs.

2. All prior accumulations toward annual benefit maximums will apply.

If renewed eligibility occurs under any circumstances other than as stated in this subsection, enrollment for coverage for the Employee and his/her Dependents will be treated as if initially hired for purposes of eligibility and coverage under this Plan.

The Reinstatement of Coverage provision is not applicable to a variable hour Employee except for any period of time that the variable hour Employee is actually enrolled and covered during the Coverage Period.

RESCISSION OF COVERAGE

Coverage for an Employee and/or Dependent may be rescinded if the Plan Administrator determines that the Employee or a Dependent engaged in fraud or intentional misrepresentation of a material fact in order to obtain coverage and/or benefits under the Plan. In such case, the Participant will receive written notice at least thirty (30) days before the coverage is rescinded.

THE NATIONAL DEFENSE AUTHORIZATION ACT (NDAA)

The National Defense Authorization Act (NDAA) expands the rights under the Family and Medical Leave Act (FMLA) of military service members and their families to include Employees caring for an injured service member as well as family members who have a family member called to active duty. NDAA permits a spouse, son, daughter, parent or next of kin to take up to 26 work-weeks of leave to care for a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy for a serious Illness or Injury. NDAA also permits an Employee to take FMLA leave for any qualifying exigency (as the Secretary of Labor shall, by regulation, determine) arising out of the fact that the spouse, son, daughter, parent or the Employee is on active duty or has been notified of an impending call or order to active duty in the Armed Forces in support of a contingency operation.

CONTINUATION COVERAGE AFTER TERMINATION

Under the Public Health Service Act, as amended, Employees and their enrolled Dependents may have the right to continue coverage beyond the time coverage would ordinarily have ended. The law applies to employers who normally employ twenty (20) or more Employees.

The Plan Administrator is The District School Board of Collier County, 5775 Osceola Trail, Naples, FL 34109-0919; (239) 377-0340. COBRA Continuation Coverage for the Plan is administered by Allegiance COBRA Services, Inc.; P.O. Box 2097, Missoula, MT 59806, (406) 721-2222; facsimile (406) 523-3131; email COBRAinquire@askallegiance.com.

COBRA Continuation Coverage is available to any Qualified Beneficiary whose coverage would otherwise terminate due to any Qualifying Event. COBRA Continuation Coverage under this provision will begin on the first day immediately following the date of the Qualifying Event.

1. Qualifying Events for Participants, for purposes of this section, are the following events, if such event results in a loss of coverage under this Plan:

   A. The termination (other than by reason of gross misconduct) of the Participant's employment.

   B. The reduction in hours of the Participant's employment.

2. Qualifying Events for covered Dependents, for purposes of this section are the following events, if such event results in a loss of coverage under this Plan:

   A. Death of the Participant or Retiree.

   B. Termination of the Participant's employment.

   C. Reduction in hours of the Participant's employment.

   D. The divorce or legal separation of the Participant or Retiree from his or her spouse.

   E. A covered Dependent child ceases to be a Dependent as defined by the Plan.

NOTIFICATION RESPONSIBILITIES

The Covered Person must notify the Employer of the following Qualifying Events within sixty (60) days after the date the event occurs. The Employer must notify the Plan Administrator of any of the following:

1. Death of the Participant or Retiree.

2. The divorce or legal separation of the Participant or Retiree from his or her spouse.

3. A covered Dependent child ceases to be a Dependent as defined by the Plan.

The Employer must notify the Plan Administrator of the following Qualifying Events within thirty (30) days after the date of the event occurs:

1. Termination (other than by reason of gross misconduct) of the Participant's employment.

2. Reduction in hours of the Participant's employment.

ELECTION OF COVERAGE

When the Plan Administrator is notified of a Qualifying Event, the Plan Administrator will notify the Qualified Beneficiary of the right to elect continuation of coverage. Notice of the right to COBRA Continuation Coverage will be sent by the Plan no later than fourteen (14) days after the Plan Administrator is notified of the Qualifying Event.

A Qualified Beneficiary has sixty (60) days from the date coverage would otherwise be lost or sixty (60) days from the date of notification from the Plan Administrator, whichever is later, to notify the Plan Administrator that he or she elects to continue coverage under the Plan. Failure to elect continuation within that period will cause coverage to end.

MONTHLY PREMIUM PAYMENTS

A Qualified Beneficiary is responsible for the full cost of continuation coverage. Monthly premium for continuation of coverage must be paid in advance to the Plan Administrator. The premium required under the provisions of COBRA is as follows:

1. For a Qualified Beneficiary: The premium is the same as applicable to any other similarly situated non-COBRA Participant plus an additional administrative expense of up to a maximum of two percent (2%).

2. Social Security Disability: For a Qualified Beneficiary continuing coverage beyond eighteen (18) months due to a documented finding of disability by the Social Security Administration within 60 days after becoming covered under COBRA, the premium may be up to a maximum of 150% of the premium applicable to any other similarly situated non-COBRA Participant.

3. For a Qualified Beneficiary with a qualifying Social Security Disability who experiences a second Qualifying Event:

    A. If another Qualifying Event occurs during the initial eighteen (18) months of COBRA coverage, such as a death, divorce or legal separation, the monthly fee for qualified disabled person may be up to a maximum of one hundred and two percent (102%) of the applicable premium.

    B. If the second Qualifying Event occurs during the nineteenth (19^{th}) through the twenty-ninth (29^{th}) month (the Disability Extension Period), the premium for a Qualified Beneficiary may be up to a maximum of one hundred fifty percent (150%) of the applicable premium.

Payment of claims while covered under this COBRA Continuation Coverage Provision will be contingent upon the receipt by the Employer of the applicable monthly premium for such coverage. The monthly premium for continuation coverage under this provision is due the first of the month for each month of coverage. A grace period of thirty (30) days from the first of the month will be allowed for payment. Payment will be made in a manner prescribed by the Employer.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If the Qualified Beneficiary who is covered under the Plan is determined by the Social Security Administration to be disabled at any time before the qualifying event or within sixty (60) days after the qualifying event, and the Plan Administrator is notified in a timely fashion, the Qualified Beneficiary covered under the Plan can receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The Plan Administrator must be provided with a copy of the Social Security Administration's disability determination letter within sixty (60) days after the date of the determination and before the end of the original 18-month period of COBRA Continuation Coverage. This notice should be sent to: Allegiance COBRA Services, Inc.; P.O. Box 2097, Missoula, MT 59806; facsimile (406) 523-3131; email COBRAinquire@askallegiance.com.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If another qualifying event occurs while receiving COBRA Continuation Coverage, the spouse and Dependent children of the Employee can get additional months of COBRA Continuation Coverage, up to a maximum of thirty-six (36) months. This extension is available to the spouse and Dependent children if the former Employee dies or becomes divorced or legally separated. The extension is also available to a Dependent child when that child stops being eligible under the Plan as a Dependent child. In all of these cases, the Plan Administrator must be notified of the second qualifying event within sixty (60) days of the second qualifying event. This notice must be sent to: Allegiance COBRA Services, Inc.; P.O. Box 2097, Missoula, MT 59806; facsimile (406) 523-3131; email COBRAinquire@askallegiance.com. Failure to provide notice within the time required will result in loss of eligibility for COBRA Continuation Coverage.

MEDICARE ENROLLMENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

The Dependents of a former Employee are eligible to elect COBRA Continuation Coverage if they lose coverage as a result of the former Employee's enrollment in Part A, Part B or Part D of Medicare, whichever occurs earlier.

When the former Employee enrolls in Medicare before the Qualifying Event of termination, or reduction in hours, of employment occurs, the maximum period for COBRA Continuation Coverage for the spouse and Dependent children ends on the later of:

1. Eighteen (18) months after the Qualifying Event of termination of employment or reduction in hours of employment; or

2. Thirty-six (36) months after the former Employee's enrollment in Medicare.

When the former Employee enrolls in Medicare after the Qualifying Event of termination, or reduction in hours, of employment, the maximum period for COBRA Continuation Coverage for the spouse and Dependent children ends eighteen (18) months after the Qualifying Event, unless a second Qualifying Event, as described above occurs within that eighteen (18) month period.

WHEN COBRA CONTINUATION COVERAGE ENDS

COBRA Continuation Coverage and any coverage under the Plan that has been elected with respect to any Qualified Beneficiary will cease on the earliest of the following:

1. On the date the Qualified Beneficiary becomes covered under another group health plan or health insurance.

2. On the date, after the date of election for COBRA Continuation Coverage, that the Qualified Beneficiary becomes enrolled in Medicare (either Part A, Part B or Part D).

3. On the first date that timely payment of any premium required under the Plan with respect to COBRA Continuation Coverage for a Qualified Beneficiary is not made to the Plan Administrator.

4. On the date the Employer ceases to provide any group health plan coverage to any Employee.

5. On the date of receipt of written notice that the Qualified Beneficiary wishes to terminate COBRA Continuation Coverage.

6. On the date that the maximum coverage period for COBRA Continuation Coverage ends, as follows:

   A. Eighteen (18) months for a former Employee who is a Qualified Beneficiary as a result of termination, or reduction in hours, of employment;

   B. Eighteen (18) months for a Dependent who is a Qualified Beneficiary unless a second Qualifying Event occurs within that eighteen month period entitling that Dependent to an additional eighteen (18) months;

   C. For the Dependent who is a Qualified Beneficiary as a result of termination, or reduction in hours, of employment of the former Employee if that former Employee enrolled in Medicare before termination, or reduction in hours, of employment, the later of eighteen (18) months from the Qualifying Event, or thirty-six (36) months following the date of enrollment in Medicare.

   D. On the first day of the month beginning thirty (30) days after a Qualified Beneficiary is determined to be no longer disabled by the Social Security Administration if the Qualified Beneficiary was found to be disabled on or within the first sixty (60) days of the date of the Qualifying Event and has received at least eighteen (18) months of COBRA Continuation Coverage. COBRA Continuation Coverage will also terminate on such date for all Dependents who are Qualified Beneficiaries as a result of the Qualifying Event unless that Dependent is entitled to a longer period of COBRA Continuation Coverage without regard to disability.

   E. Twenty-nine (29) months for any Qualified Beneficiary if a Disability Extension Period of COBRA Continuation Coverage has been granted for such Qualified Beneficiary.

   F. Thirty-six (36) months for all other Qualified Beneficiaries.

7. On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA Participant.

QUESTIONS

Any questions about COBRA Continuation Coverage should be directed to Allegiance COBRA Services, Inc. or contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

INFORM THE PLAN OF ADDRESS CHANGES

In order to protect the Employee's family's rights, the Employee should keep the Plan Administrator informed of any changes in the addresses of family members. The Employee should also keep a copy, for his/her records, of any notices sent to the Plan Administrator.

COVERAGE FOR A MILITARY RESERVIST

To the extent required by the Uniform Services Employment and Reemployment Rights Act (USERRA), the following provisions will apply:

1. If a Participant is absent from employment with Employer by reason of service in the uniformed services, the Participant may elect to continue coverage under this Plan for himself or herself and his or her eligible Dependents as provided in this subsection. The maximum period of coverage under such an election will be the lesser of:

   A. The twenty-four (24) month period beginning on the date on which the Participant's absence begins; or

   B. The period beginning on the date on which the Participant's absence begins and ending on the day after the date on which the Participant fails to apply for or return to a position of employment, as required by USERRA.

2. A Participant who elects to continue Plan coverage under this Section may be required to pay not more than one hundred two percent (102%) of the full premium under the Plan (determined in the same manner as the applicable premium under Section 4980B(f)(4) of the Internal Revenue Code of 1986) associated with such coverage for the Employer's other Employees, except that in the case of a person who performs service in the uniformed services for less than thirty-one (31) days, such person may not be required to pay more than the regular Employee share, if any, for such coverage.

3. In the case of a Participant whose coverage under the Plan is terminated by reason of service in the uniformed services, an exclusion or Waiting Period may not be imposed in connection with the reinstatement of such coverage upon reemployment if an exclusion or Waiting Period would not have been imposed under the Plan had coverage of such person by the Plan not been terminated as a result of such service. This paragraph applies to the Employee who notifies the Employer of his or her intent to return to employment in a timely manner as defined by USERRA, and is reemployed and to any Dependent who is covered by the Plan by reason of the reinstatement of the coverage of such Employee. This provision will not apply to the coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been caused by or aggravated during, performance of service in the uniformed services.

4. The requirements of this section shall not supersede any anti discrimination in coverage requirement promulgated by TriCare or Champus/VA related to eligibility for those coverages.

FRAUD AND ABUSE

THIS PLAN IS SUBJECT TO FEDERAL LAW WHICH PERMITS CRIMINAL PENALTIES FOR FRAUDULENT ACTS COMMITTED AGAINST THE PLAN. STATE LAW MAY ALSO APPLY.

Anyone who knowingly defrauds or tries to defraud the Plan, or obtains Plan funds through false statements or fraudulent schemes, may be subject to criminal prosecution and penalties. The following may be considered fraudulent:

1. Falsifying eligibility criteria for a Dependent to get or continue coverage for that Dependent when not otherwise eligible for coverage;

2. Falsifying or withholding medical history or information required to calculate benefits;

3. Falsifying or altering documents to get coverage or benefits;

4. Permitting a person not otherwise eligible for coverage to use a Plan ID card to get Plan benefits; or

5. Submitting a fraudulent claim or making untruthful statements to the Plan to get reimbursement from the Plan for services that may or may not have been provided to a Covered Person.

The Plan Administrator, in its sole discretion, may take additional action against the Participant or Covered Person including, but not limited to, terminating the Participant or Covered Person's coverage under the Plan.

MISSTATEMENT OF AGE

If the Covered Person's age was misstated upon enrollment or claim, the Covered Person's eligibility or amount of benefits, or both, will be adjusted to reflect the Covered Person's true age. If the Covered Person was not eligible for coverage under the Plan or for the amount of benefits received, the Plan has a right to recover any benefits paid by the Plan. A misstatement of age will not continue coverage that was otherwise properly terminated or terminate coverage that is otherwise validly in force.

MISREPRESENTATION OF ELIGIBILITY

If a Participant misrepresents a Dependent's marital status, age, student status, Dependent child relationship or other eligibility criteria to get coverage for that Dependent, when he or she would not otherwise be eligible, coverage for that Dependent will terminate as though never effective.

MISUSE OF IDENTIFICATION CARD

If a Covered Person permits any person who is not otherwise eligible as a Covered Person to use an ID card, the Plan Sponsor may, at the Plan Sponsor's sole discretion, terminate the Covered Person's coverage.

REIMBURSEMENT TO PLAN

Payment of benefits by the Plan for any person who was not otherwise eligible for coverage under this Plan but for whom benefits were paid based upon fraud as defined in this section must be reimbursed to the Plan by the Participant. Failure to reimburse the Plan upon request may result in an interruption or a loss of benefits by the Participant and Dependents.

RESCISSION OF COVERAGE

Coverage for an Employee and/or Dependent may be rescinded if the Plan Administrator determines that the Employee or a Dependent engaged in fraud or intentional misrepresentation of a material fact in order to obtain coverage and/or benefits under the Plan. In such case, the Participant will receive written notice at least thirty (30) days before the coverage is rescinded.

RECOVERY/REIMBURSEMENT/SUBROGATION

By enrollment in this Plan, Covered Persons agree to the provisions of this section as a condition precedent to receiving benefits under this Plan. Failure of a Covered Person to comply with the requirements of this section may result in the Plan pending the payment of benefits.

RIGHT TO RECOVER BENEFITS PAID IN ERROR

If the Plan makes a payment in error to or on behalf of a Covered Person or an assignee of a Covered Person to which that Covered Person is not entitled, or if the Plan pays a claim that is not covered, the Plan has the right to recover the payment from the person paid or anyone else who benefitted from the payment. The Plan can deduct the amount paid from the Covered Person's future benefits, or from the benefits for any covered Family member even if the erroneous payment was not made on that Family member's behalf.

Payment of benefits by the Plan for Participants' spouses, ex-spouses, or children, who are not eligible for coverage under this Plan, but for whom benefits were paid based upon inaccurate, false information provided by, or information omitted by, the Employee will be reimbursed to the Plan by the Employee. The Employee's failure to reimburse the Plan after demand is made, may result in an interruption in or loss of benefits to the Employee, and could be reported to the appropriate governmental authorities for investigation of criminal fraud.

The Plan may recover such amount by any appropriate method that the Plan Administrator, in its sole discretion, will determine.

The provisions of this section apply to any Physician or Licensed Health Care Provider who receives an assignment of benefits or payment of benefits under this Plan. If a Physician or Licensed Health Care Provider fails to refund a payment of benefits, the Plan may refuse to recognize future assignments of benefits to that provider.

REIMBURSEMENT

The Plan's right to Reimbursement is separate from and in addition to the Plan's right of Subrogation. If the Plan pays benefits for medical expenses on a Covered Person's behalf, and another party was responsible or liable for payment of those medical expenses, the Plan has a right to be reimbursed by the Covered Person for the amounts the Plan paid.

Accordingly, if a Covered Person, or anyone on his or her behalf, settles, is reimbursed or recovers money from any person, corporation, entity, liability coverage, no-fault coverage, uninsured coverage, underinsured coverage, or other insurance policies or funds for any accident, Injury, condition or Illness for which benefits were provided by the Plan, the Covered Person agrees to hold the money received in trust for the benefit of the Plan. The Covered Person agrees to reimburse the Plan, in first priority, from any money recovered from a liable third party, for the amount of all money paid by the Plan to the Covered Person or on his or her behalf or that will be paid as a result of said accident, Injury, condition or Illness. Reimbursement to the Plan will be paid first, in its entirety, even if the Covered Person is not paid for all of his or her claim for damages and regardless of whether the settlement, judgment or payment he or she receives is for or specifically designates the recovery, or a portion thereof, as including health care, medical, disability or other expenses or damages.

SUBROGATION

The Plan's right to Subrogation is separate from and in addition to the Plan's right to Reimbursement. Subrogation is the right of the Plan to exercise the Covered Person's rights and remedies in order to recover from any third party who is liable to the Covered Person for a loss or benefits paid by the Plan. The Plan may proceed through litigation or settlement in the name of the Covered Person, with or without his or her consent, to recover benefits paid under the Plan.

The Covered Person agrees to subrogate to the Plan any and all claims, causes of action or rights that he or she has or that may arise against any entity who has or may have caused, contributed to or aggravated the accident, Injury, condition or Illness for which the Plan has paid benefits, and to subrogate any claims, causes of action or rights the Covered Person may have against any other coverage including, but not limited to, liability coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, or other insurance policies, coverage or funds.

In the event that a Covered Person decides not to pursue a claim against any third party or insurer, the Covered Person will notify the Plan, and specifically authorize the Plan, in its sole discretion, to sue for, compromise or settle any such claims in the Covered Person's name, to cooperate fully with the Plan in the prosecution of the claims, and to execute any and all documents necessary to pursue those claims.

The Following Paragraphs Apply to Both Reimbursement and Subrogation:

1. Under the terms of this Plan, the Third Party Administrator is not required to pay any claim where there is evidence of liability of a third party unless the Covered Person signs the Plan's Third-Party Reimbursement Agreement and follows the requirements of this section. However, the Plan, in its discretion, may instruct the Third Party Administrator not to withhold payment of benefits while the liability of a party other than the Covered Person is being legally determined. If a repayment agreement is requested to be signed, the Plan's right of recovery through Reimbursement and/or Subrogation remains in effect regardless of whether the repayment agreement is actually signed.

2. If the Plan makes a payment which the Covered Person, or any other party on the Covered Person's behalf, is or may be entitled to recover against any liable third party, this Plan has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment.

3. The Covered Person will cooperate fully with the Plan Administrator, its agents, attorneys and assigns, regarding the recovery of any benefits paid by the Plan from any liable third party. This cooperation includes, but is not limited to, make full and complete disclosure in a timely manner of all material facts regarding the accident, Injury, condition or Illness to the Plan Administrator; report all efforts by any person to recover any such monies; provide the Plan Administrator with any and all requested documents, reports and other information in a timely manner, regarding any demand, litigation or settlement involving the recovery of benefits paid by the Plan; and notify the Plan Administrator of the amount and source of funds received from third parties as compensation or damages for any event from which the Plan may have a reimbursement or subrogation claim.

4. Covered Persons will respond within ten (10) days to all inquiries of the Plan regarding the status of any claim they may have against any third parties or insurers including, but not limited to, liability, no-fault, uninsured and underinsured insurance coverage. The Covered Person will notify the Plan immediately of the name and address of any attorney whom the Covered Person engages to pursue any personal Injury claim on his or her behalf.

5. The Covered Person will not act, fail to act, or engage in any conduct directly, indirectly, personally or through third parties, either before or after payment by the Plan, the result of which may prejudice or interfere with the Plan's rights to recovery hereunder. The Covered Person will not conceal or attempt to conceal the fact that recovery has occurred or will occur.

6. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Covered Person pursuing a claim against any third party or coverage including, but not limited to, attorney fees or costs of litigation. Monies paid by the Plan will be repaid in full, in first priority, notwithstanding any anti-subrogation, "made whole," "common fund" or similar statute, regulation, prior court decision or common law theory unless a reduction or compromise settlement is agreed to in writing or required pursuant to a court order.

RIGHT OF OFF-SET

The Plan has a right of off-set to satisfy reimbursement claims against Covered Persons for money received by the Covered Person from a third party, including any insurer. If the Covered Person fails or refuses to reimburse the Plan for funds paid for claims, the Plan may deny payment of future claims of the Covered Person, up to the full amount paid by the Plan and subject to reimbursement for such claims. This right of off-set applies to all reimbursement claims owing to the Plan whether or not formal demand is made by the Plan, and notwithstanding any anti-subrogation, "common fund", "made whole" or similar statutes, regulations, prior court decisions or common law theories.

PLAN ADMINISTRATION

PURPOSE

The purpose of the Plan Document is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of the claim. The terms of this Plan are legally enforceable and the Plan is maintained for the exclusive benefit of eligible Employees and their covered Dependents.

EFFECTIVE DATE

The effective date of the Plan is January 1, 2013, restated March 1, 2020.

PLAN YEAR

The Plan Year will commence January 1st and end on December 31st of each year.

PLAN SPONSOR

The Plan Sponsor is The District School Board of Collier County.

THIRD PARTY ADMINISTRATOR

The Third Party Administrator for the Plan is Allegiance Benefit Plan Management, Inc.

NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The Named Fiduciary and Plan Administrator is The District School Board of Collier County, a political subdivision of the State of Florida, who has the authority to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The Plan Administrator will have the authority to amend the Plan, to determine its policies, to appoint and remove other service providers of the Plan, to fix their compensation (if any), and exercise general administrative authority over them and the Plan. The Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder.

PLAN INTERPRETATION

The Named Fiduciary and Plan Sponsor have full discretionary authority to interpret and apply all Plan provisions including, but not limited to, resolving all issues concerning eligibility and determination of benefits. The Plan Administrator may contract with an independent administrative firm to process claims, maintain Plan data, and perform other Plan-connected services. Final authority to interpret and apply the provisions of the Plan rests exclusively with the Plan Administrator. Decisions of the Plan Administrator made in good faith will be final and binding.

CONTRIBUTIONS TO THE PLAN

The amount of contributions to the Plan are to be made on the following basis:

> The Employer will from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Employer, if any, and the amount to be contributed, if any, by each Participant.
>
> If the Employer terminates the Plan, the Employer and Participants will have no obligation to contribute to the Plan after the date of termination.

PLAN AMENDMENTS/MODIFICATION/TERMINATION

The Plan Document contains all the terms of the Plan and may be amended at any time by the Plan Administrator. Any changes will be binding on each Participant and on any other Covered Persons referred to in this Plan Document. The authority to amend the Plan is delegated by the Plan Administrator to the Executive Director, Human Resources, or designee, of the Employer. Any such amendment, modification, revocation or termination of the Plan will be authorized and signed by the Executive Director, Human Resources, or designee, of the Employer. Written notification of any amendments, modifications, revocations or terminations will be given to Plan Participants at least sixty (60) days prior to the effective date, except for amendments effective on the first day of a new Plan Year, for which thirty (30) days advance notice is required.

TERMINATION OF PLAN

The Employer reserves the right at any time to terminate the Plan by a written notice. All previous contributions by the Employer will continue to be issued for the purpose of paying benefits and fixed costs under provisions of this Plan with respect to claims arising before such termination, or will be used for the purpose of providing similar health benefits to Participants, until all contributions are exhausted.

SUMMARY PLAN DESCRIPTIONS

Each Participant covered under this Plan will be issued a Summary Plan Description (SPD) describing the benefits to which the Covered Persons are entitled, the required Plan procedures for eligibility and claiming benefits and the limitations and exclusions of the Plan.

GENERAL PROVISIONS

EXAMINATION

The Plan will have the right and opportunity to have the Covered Person examined whenever Injury or Illness is the basis of a claim when and so often as it may reasonably require to adjudicate the claim. The Plan will also have the right to have an autopsy performed in case of death to the extent permitted by law.

PAYMENT OF CLAIMS

All Plan benefits are payable to a Participant, Qualified Beneficiary or Alternate Recipient, whichever is applicable. All or a portion of any benefits payable by the Plan may, at the Covered Person's option and unless the Covered Person requests otherwise in writing not later than the time of filing the claim, be paid directly to the health care provider rendering the service, if proper written assignment is provided to the Plan. No payments will be made to any provider of services unless the Covered Person is liable for such expenses.

If any benefits remain unpaid at the time of the Covered Person's death or if the Covered Person is a minor or is, in the opinion of the Plan, legally incapable of giving a valid receipt and discharge for any payment, the Plan may, at its option, pay such benefits to the Covered Person's legal representative or estate. The Plan, in its sole option, may require that an estate, guardianship or conservatorship be established by a court of competent jurisdiction prior to the payment of any benefit. Any payment made under this subsection will constitute a complete discharge of the Plan's obligation to the extent of such payment and the Plan will not be required to oversee the application of the money so paid.

LEGAL PROCEEDINGS

No action at law or equity will be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, nor will such action be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Plan.

The appropriate jurisdiction for any litigation under this Plan will be those courts located within the State of Florida. Litigation in the federal courts will be in the appropriate district court in the State of Florida.

NO WAIVER OR ESTOPPEL

No term, condition or provision of this Plan will be waived, and there will 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 will be deemed a continuing waiver unless specifically stated therein, and each such waiver will operate only as to the specific term or condition waived and will not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

VERBAL STATEMENTS

Verbal statements or representations of the Plan Administrator, its agents and Employees, or Covered Persons will not create any right by contract, estoppel, unjust enrichment, waiver or other legal theory regarding any matter related to the Plan, or its administration, except as specifically stated in this subsection. No statement or representation of the Plan Administrator, its agents and Employees, or Covered Persons will be binding upon the Plan or a Covered Person unless made in writing by a person with authority to issue such a statement. This subsection will not be construed in any manner to waive any claim, right or defense of the Plan or a Covered Person based upon fraud or intentional material misrepresentation of fact or law.

FREE CHOICE OF PHYSICIAN

The Covered Person will have free choice of any licensed Physician, Licensed Health Care Provider or surgeon and the patient-provider relationship will be maintained.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of, supplemental to Workers' Compensation and does not affect any requirement for coverage by Workers' Compensation Insurance.

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of the applicable law. Only that provision which is contrary to applicable law will be amended to conform; all other parts of the Plan will remain in full force and effect.

MISCELLANEOUS

Section titles are for convenience of reference only, and are not to be considered in interpreting this Plan.

No failure to enforce any provision of this Plan will affect the right thereafter to enforce such provision, nor will such failure affect its right to enforce any other provision of the Plan.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan or plans, the Plan will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it determines in order to satisfy the intent of this provision. Amounts so paid will be deemed to be benefits paid under this Plan and to the extent of such payments, the Plan will be fully discharged from liability under this Plan.

The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan will 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 will be void, except an assignment of payment to a provider of Covered Services. If the Plan Administrator finds that such an attempt has been made with respect to any payment due or which will 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. In such case, the Plan Administrator will apply the amount of such payment to or for the benefit of such Participant or covered Dependents or former Participant, as the Plan Administrator may determine. Any such application will be a complete discharge of all liability of the Plan with respect to such benefit payment.

PLAN IS NOT A CONTRACT

The Plan Document constitutes the primary authority for Plan administration. The establishment, administration and maintenance of this Plan will not be deemed to constitute a contract of employment, give any Participant of the Employer the right to be retained in the service of the Employer, or to interfere with the right of the Employer to discharge or otherwise terminate the employment of any Participant.

GENERAL DEFINITIONS

Certain words and phrases in this Plan Document are defined below and references of such words or phrases will be capitalized when used throughout the Plan Document. The failure of a word or phrase to appear capitalized does not waive the special meaning given to that word or phrase, unless the context requires otherwise. If the defined term is not used in this document, the term does not apply to this Plan.

Masculine pronouns used in this Plan Document will include either the masculine or feminine gender unless the context indicates otherwise.

Any words used herein in the singular or plural will include the alternative as applicable.

ACCIDENTAL INJURY

"Accidental Injury" means an Injury sustained as a result of an external force or forces that is/are sudden, direct and unforeseen and is/are exact as to time and place. A hernia of any kind will only be considered as an Illness.

ACTIVE SERVICE

"Active Service" means that an Employee is in service with the Employer on a day which is one of the Employer's regularly scheduled work days and that the Employee is performing all of the regular duties of his/her employment with the Employer on a regular basis, either at one of the Employer's business establishments or at some location to which the Employer's business requires him/her to travel.

ADVERSE BENEFIT DETERMINATION

"Adverse Benefit Determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's or beneficiary's eligibility to participate in the Plan, and including, with respect to group health plans, 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, as well as 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, or a rescission of coverage if the Plan Administrator determines that the Employee or a Dependent engaged in fraud or intentional misrepresentation of a material fact in order to obtain coverage and/or benefits under the Plan. In such case, the Participant will receive written notice at least thirty (30) days before the coverage is rescinded.

ALCOHOLISM

"Alcoholism" means a morbid state caused by excessive and compulsive consumption of alcohol that interferes with the patient's health, social or economic functioning.

AMBULANCE SERVICE

"Ambulance Service" means an entity, its personnel and equipment including, but not limited to, automobiles, airplanes, boats or helicopters, which are licensed to provide Emergency medical and Ambulance services in the state in which the services are rendered.

AMBULATORY SURGICAL CENTER

"Ambulatory Surgical Center" (also called same-day surgery center or Outpatient surgery center) means a licensed establishment with an organized staff of Physicians and permanent facilities, either freestanding or as a part of a Hospital, equipped and operated primarily for the purpose of performing surgical procedures and which a patient is admitted to and discharged from within a twenty-four (24) hour period. Such facilities must provide continuous Physician and registered nursing services whenever a patient is in the facility. An Ambulatory Surgical Center must meet any requirements for certification or licensing for ambulatory surgery centers in the state in which the facility is located.

"Ambulatory Surgical Center" does not include an office or clinic maintained by a Dentist or Physician for the practice of dentistry or medicine, a Hospital emergency room or trauma center.

BENEFIT PERCENTAGE

"Benefit Percentage" means that portion of Eligible Expenses payable by the Plan, which is stated as a percentage in the Schedule of Benefits.

BENEFIT PERIOD

"Benefit Period" refers to a time period of one year, which is either a Calendar Year or other annual period, as shown in the Schedule of Benefits. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of the one year period so established; or

2. The date the Plan terminates.

BIRTHING CENTER

A "Birthing Center" means a freestanding or hospital based facility which provides obstetrical delivery services under the supervision of a Physician, and through an arrangement or an agreement with a Hospital.

CALENDAR YEAR

"Calendar Year" means a period of time commencing on January 1 and ending on December 31 of the same year.

CERTIFIED NURSE MIDWIFE

"Certified Nurse Midwife" means an individual who has received advanced nursing training and is authorized to use the designation of "CNM" and who is licensed by the state or regulatory agency in the state in which the individual performs such nursing services.

CHEMICAL DEPENDENCY

"Chemical Dependency" means the physiological and psychological addiction to a controlled drug or substance, or to alcohol. Dependence upon tobacco, nicotine, caffeine or eating disorders are not included in this definition.

CHIROPRACTIC SERVICES

"Chiropractic Services" means 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.

CLOSE RELATIVE

"Close Relative" means the spouse, parent, brother, sister, child, or in-laws of the Covered Person.

COBRA

"COBRA" means Sections 2201 through 2208 of the Public Health Service Act [42 U.S.C. § 300bb-1 through § 300bb-8], which contains provisions similar to Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA CONTINUATION COVERAGE

"COBRA Continuation Coverage" means continuation coverage provided under the provisions of the Public Health Service Act referenced herein under the definition of "COBRA".

CONTRACEPTIVE MANAGEMENT

"Contraceptive Management" means Physician fees related to a prescription contraceptive device, obtaining a prescription for contraceptives, purchasing, fitting, injecting, implantation, placement or removal of any contraceptive device.

CONVALESCENT NURSING FACILITY

See "Skilled Nursing Facility".

COSMETIC

"Cosmetic" means services or treatment ordered or performed solely to change a Covered Person's appearance rather than for the restoration of bodily function.

COVERED PERSON

"Covered Person" means any Participant or Dependent of a Participant meeting the eligibility requirements for coverage and properly enrolled for coverage as specified in the Plan.

CUSTODIAL CARE

"Custodial Care" means the type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

DEDUCTIBLE

"Deductible" means a specified dollar amount that must be incurred before the Plan will pay any amount for any benefit during each Benefit Period.

DEPENDENT

"Dependent" means a person who is eligible for coverage under the Dependent Eligibility subsection of this Plan.

DEPENDENT COVERAGE

"Dependent Coverage" means eligibility for coverage under the terms of the Plan for benefits payable as a consequence of Eligible Incurred Expenses for an Illness or Injury of a Dependent.

DURABLE MEDICAL EQUIPMENT

"Durable Medical Equipment" means equipment which is:

1. Able to withstand repeated use, i.e., could normally be rented, and used by successive patients; and

2. Primarily and customarily used to serve a medical purpose; and

3. Not generally useful to a person in the absence of Illness or Injury.

ELIGIBLE EXPENSES

"Eligible Expenses" means the maximum amount of any charge for a covered service, treatment or supply that may be considered for payment by the Plan, including any portion of that charge that may be applied to the Deductible or used to satisfy the Out-of-Pocket Maximum. Eligible Expenses are equal to the actual billed charge or UCR, whichever is less or a contracted or negotiated rate, if applicable.

EMERGENCY

"Emergency" means acute symptoms that a prudent layperson, possessing average knowledge of health and medicine, would expect that in the absence of medical attention would place the individual's health in serious jeopardy, or seriously impair body functions, organs or parts.

EMPLOYEE

"Employee" means a person employed by the Employer on a continuing and regular basis who is a common-law Employee and who is on the Employer's W-2 payroll.

Employee does not include any Employee leased from another employer including, but not limited to, those individuals defined in Internal Revenue Code Section 414(n), or an individual classified by the Employer as a contract worker or independent contractor if such persons are not on the Employer's W-2 payroll, or any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc.

EMPLOYER

"Employer" means The District School Board of Collier County, or any affiliated agencies or boards that have adopted this Plan for its Employees.

ENROLLMENT DATE

"Enrollment Date" means the date a person becomes eligible for coverage and meets the eligibility criteria under this Plan or the eligible person's effective date of coverage under this Plan, whichever occurs first.

EXPERIMENTAL/INVESTIGATIONAL

"Experimental/Investigational" means:

1. Any drug or device that 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; or

2. Any drug, device, medical treatment or procedure for which the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

3. That the drug, device or medical treatment or procedure is under study, prior to or in the absence of any clinical trial, to determine its maximum tolerated dose, its toxicity, or its safety, or

4. That based upon Reliable Evidence, the drug, device, medical treatment or procedure is the subject of an on-going Phase I or Phase II clinical trial. (A Phase III clinical trial recognized by the National Institute of Health is not considered Experimental or Investigational.) For chemotherapy regimens, a Phase II clinical trial is not considered Experimental or Investigational when both of these criteria are met:

    A. The regimen or protocol has been the subject of a completed and published Phase II clinical trial which demonstrates benefits equal to or greater than existing accepted treatment protocols, and

    B. The regimen or protocol listed by the National Comprehensive Cancer Network is supported by level of evidence Category 2B or higher; or

5. Based upon Reliable Evidence, any drug, device, medical treatment or procedure that the prevailing opinion among experts is that further studies or clinical trial are necessary to determine the maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with generally medically accepted means of treatment or diagnosis; or

6. Any drug, device, medical treatment or procedure used in a manner outside the scope of use for which it was approved by the FDA or other applicable regulatory authority (U.S. Department of Health, Centers for Medicare and Medicaid Services (CMS), American Dental Association, American Medical Association).

"Reliable Evidence" means only reports and articles published in authoritative medical and scientific literature; the written protocol or protocols used by a treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the informed consent document used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

FAMILY

"Family" means a Participant and his or her eligible Dependents as defined herein.

FMLA

"FMLA" means Family and Medical Leave Act.

GENDER IDENTITY DISORDER/ GENDER DYSPHORIA

The terms "Gender Identity Disorder" and "Gender Dysphoria" shall be defined and understood in accordance with the Diagnostic Statistical Manual ("DSM"), the most current of which is the DSM-V.

HIPAA

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

HOME HEALTH CARE AGENCY

"Home Health Care Agency" means an organization that provides skilled nursing services and therapeutic services (home health aide services, physical therapy, occupational therapy, speech therapy, #medical social services) on a visiting basis, in a place of residence used as the Covered Person's home. The organization must be Medicare certified and licensed within the state in which home health care services are provided.

HOME HEALTH CARE PLAN

“Home Health Care Plan” means a program for continued care and treatment administered by a Medicare certified and licensed Home Health Care Agency, for the Covered Person who may otherwise have been confined as an Inpatient in a Hospital or Skilled Nursing Facility or following termination of a Hospital confinement as an Inpatient and is the result of the same related condition for which the Covered Person was hospitalized and is approved in writing by the Covered Person's attending Physician.

HOSPICE

“Hospice” means a health care program providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one Registered Nurse (RN), and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

HOSPICE BENEFIT PERIOD

“Hospice Benefit Period” means a specified amount of time during which the Covered Person undergoes treatment by a Hospice. Such time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminal Illness, and the Covered Person is accepted into a Hospice program. The period will end the earliest of six months from this date or at the death of the Covered Person. A new Hospice Benefit Period may begin if the attending Physician certifies that the patient is still terminally ill; however, additional proof will be required by the Plan Administrator before a new Hospice Benefit Period can begin.

HOSPITAL

“Hospital” means an institution which meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an emergent or Inpatient basis at the patient's expense; and

2. It is licensed as a hospital or a critical access hospital under the laws of the jurisdiction in which the facility is located; and

3. It maintains on its premises the facilities necessary to provide for the diagnosis and treatment of an Illness or an Injury or provides for the facilities through arrangement or agreement with another hospital; and

4. It provides treatment by or under the supervision of a Physician or osteopathic Physician with nursing services by registered nurses as required under the laws of the jurisdiction in which the facility is licensed; and

5. It is a provider of services under Medicare. This condition is waived for otherwise Eligible Incurred Expenses outside of the United States; and

6. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

HOSPITAL MISCELLANEOUS EXPENSES

“Hospital Miscellaneous Expenses” mean the actual charges made by a Hospital on its own behalf for services and supplies rendered to the Covered Person which are Medically Necessary for the treatment of such Covered Person. Hospital Miscellaneous Expenses do not include charges for Room and Board or for professional services, regardless of whether the services are rendered under the direction of the Hospital or otherwise.

ILLNESS

"Illness" means a bodily disorder, Pregnancy, disease, physical sickness, Mental Illness, or functional nervous disorder of a Covered Person.

INCURRED EXPENSES OR EXPENSES INCURRED

"Incurred Expenses" or "Expenses Incurred" means those services and supplies rendered to a Covered Person. Such expenses will be considered to have occurred at the time or date the treatment, service or supply is actually provided.

INITIAL ENROLLMENT PERIOD

"Initial Enrollment Period" means the time allowed by this Plan for enrollment when a person first becomes eligible for coverage.

INJURY

"Injury" means physical damage to the Covered Person's body which is not caused by disease or bodily infirmity.

IN-NETWORK PROVIDER

"In-Network Provider" means using a Physician who is part of the group of contracted providers.

INPATIENT

"Inpatient" means the classification of a Covered Person when that person is admitted to a Hospital, Hospice, or Skilled Nursing Facility for treatment, and charges are made for Room and Board to the Covered Person as a result of such treatment.

INTENSIVE CARE UNIT

"Intensive Care Unit" means a section, ward, or wing within the Hospital which is separated from other facilities and:

1. Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients;

2. It has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and

3. It provides constant observation and treatment by Registered Nurses (RNs) or other highly-trained Hospital personnel.

LICENSED HEALTH CARE PROVIDER

"Licensed Health Care Provider" means any provider of health care services who is licensed or certified by any applicable governmental regulatory authority to the extent that services are within the scope of the license or certification and are not specifically excluded by this Plan.

LICENSED PRACTICAL NURSE

"Licensed Practical Nurse" means an individual who has received specialized nursing training and practical nursing experience, and is licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

LICENSED SOCIAL WORKER

"Licensed Social Worker" means a person holding a Masters Degree (MSW) in social work and who is currently licensed as a social worker in the state in which services are rendered, and who provides counseling and treatment in a clinical setting for Mental Illnesses.

MEDICAID

"Medicaid" means that program of medical care and coverage established and provided by Title XIX of the Social Security Act, as amended.

MEDICAL POLICY

"Medical Policy" means a policy adopted by the Plan which is created and updated by Physicians and other medical providers and is used to determine whether health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:

1. Final approval from the appropriate governmental regulatory agencies;

2. Scientific studies showing conclusive evidence of improved net health outcome; and

3. In accordance with any established standards of good medical practice.

MEDICALLY NECESSARY OR MEDICAL NECESSITY

"Medically Necessary" or "Medical Necessity" means treatment, tests, services or supplies provided by a Hospital, Physician, or other Licensed Health Care Provider which are not excluded under this Plan and which meet all of the following criteria:

1. Are to treat or diagnose an Illness or Injury; and

2. Are ordered by a Physician or Licensed Health Care Provider and are consistent with the symptoms or diagnosis and treatment of the Illness or Injury; and

3. Are not primarily for the convenience of the Covered Person, Physician or other Licensed Health Care Provider; and

4. Are the standard or level of services most appropriate for good medical practice that can be safely provided to the Covered Person and are in accordance with the Plan's Medical Policy; and

5. Are not of an Experimental/Investigational or solely educational nature; and

6. Are not provided primarily for medical or other research; and

7. Do not involve excessive, unnecessary or repeated tests; and

8. Are commonly and customarily recognized by the medical profession as appropriate in the treatment or diagnosis of the diagnosed condition; and

9. Are approved procedures or meet required guidelines or protocols of the Food and Drug Administration (FDA) or Centers For Medicare/Medicaid Services (CMS), pursuant to that entity's program oversight authority based upon the medical treatment circumstances.

MEDICARE

"Medicare" means the programs established under the "Health Insurance for the Aged Act," Public Law 89-97 under Title XVIII of the Federal Social Security Act, as amended, to pay for various medical expenses for qualified individuals, specifically those who are eligible for Medicare Part A, Part B or Part D as a result of age, those with end-stage renal disease, or with disabilities.

MENTAL ILLNESS

"Mental Illness" means a medically recognized psychological, physiological, nervous or behavioral condition, affecting the brain, which can be diagnosed and treated by medically recognized and accepted methods, but will not include Substance Abuse, Chemical Dependency or other addictive behavior. Conditions recognized by the Diagnostic Statistical Manual (the most current edition) will be included in this definition.

MORBID OBESITY

"Morbid Obesity" means a diagnosed condition in which the body weight exceeds the normal weight by either 100 pounds or is twice the normal weight of a person the same height, and conventional weight reduction measures have failed.

The excess weight must cause a medical condition such as physical trauma, pulmonary and circulatory insufficiency, diabetes or heart disease.

NAMED FIDUCIARY

"Named Fiduciary" means the Plan Administrator which has the authority to control and manage the operation and administration of the Plan.

NEWBORN

Vaginal delivery: "Newborn" refers to an infant from the date of his/her birth until the initial Hospital discharge or forty-eight (48) hours, whichever occurs first.

Cesarean section delivery: "Newborn" refers to an infant from the date of his/her birth until the initial Hospital discharge or ninety-six (96) hours, whichever occurs first.

OCCUPATIONAL THERAPY

"Occupational Therapy" means a program of care ordered by a Physician which is for the purpose of improving the physical, cognitive and perceptual disabilities that influence the Covered Person's ability to perform functional tasks related to normal life functions or occupations, and which is for the purpose of assisting the Covered Person in performing such functional tasks without assistance.

ORAL SURGERY

"Oral Surgery" means necessary procedures for surgery in the oral cavity, including pre- and post-operative care.

ORTHOPEDIC APPLIANCE

"Orthopedic Appliance" means a rigid or semi-rigid support used to restrict or eliminate motion in a diseased, injured, weak or deformed body member.

OUT-OF-NETWORK PROVIDER

"Out-of-Network Provider" means a provider who is not an In-Network Provider.

OUT-OF-POCKET MAXIMUM

"Out-of-Pocket Maximum" means the maximum dollar amount, as stated in the Schedule of Medical Benefits or Pharmacy Benefit, that any Covered Person or Family will pay in any Benefit Period for covered services, treatments or supplies.

OUTPATIENT

"Outpatient" means a Covered Person who is receiving medical care, treatment, services or supplies at a clinic, a Physician's office, a Licensed Health Care Provider's office or at a Hospital if not a registered bedpatient at that Hospital, Psychiatric Facility or Substance Abuse and/or Chemical Dependency Treatment Facility.

PARTIAL HOSPITALIZATION

"Partial Hospitalization" means care in a day care or night care facility for a minimum of twenty (20) hours week, during which therapeutic clinical treatment is provided.

PARTICIPANT

"Participant" means an Employee of the Employer who is eligible and enrolled for coverage under this Plan.

PHYSICAL THERAPY

"Physical Therapy" means a plan of care ordered by a Physician and provided by a licensed physical therapist, to return the Covered Person to the highest level of motor functioning possible.

PHYSICIAN

"Physician" means a person holding the degree of Doctor of Medicine, Dentistry or Osteopathy, or Optometry who is legally licensed as such.

"Physician" does not include the Covered Person or any Close Relative of the Covered Person who does not regularly charge the Covered Person for services.

PLACEMENT OR PLACED FOR ADOPTION

"Placement" or "Placed for Adoption" means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's Placement for Adoption with such person ends upon the termination of such legal obligation.

PLAN

"Plan" means the Health Benefit Plan for Employees of The District School Board of Collier County, the Plan Document and any other relevant documents pertinent to its operation and maintenance.

PLAN ADMINISTRATOR

"Plan Administrator" means The District School Board of Collier County, and/or its designee which is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. For the purposes of any applicable state legislation of a similar nature, the Employer will be deemed to be the Plan Administrator of the Plan unless the Employer designates an individual or committee to act as Plan Administrator of the Plan.

PREGNANCY

"Pregnancy" means a physical condition commencing with conception, and ending with miscarriage or birth.

PREVENTIVE CARE

"Preventive Care" means routine treatment or examination provided when there is no objective indication or outward manifestation of impairment of normal health or normal bodily function, and which is not provided as a result of any Injury or Illness.

PRIMARY CARE PHYSICIAN

"Primary Care Physician" includes Family Practice, General Practice, Internal Medicine, Obstetrics and Gynecology (OB/Gyn) or Pediatrics, and their associated Physician Assistants, Licensed Nurse Practitioners and Certified Nurse Midwives.

PROSTHETIC APPLIANCE

"Prosthetic Appliance" means a device or appliance that is designed to replace a natural body part lost or damaged due to Illness or Injury, the purpose of which is to restore full or partial bodily function or appearance, or in the case of Covered Dental Benefit, means any device which replaces all or part of a missing tooth or teeth.

PSYCHIATRIC CARE

"Psychiatric Care," also known as psychoanalytic care, means treatment for a Mental Illness or disorder, a functional nervous disorder, Alcoholism or drug addiction by a licensed psychiatrist, Psychologist, Licensed Social Worker or licensed professional counselor acting within the scope and limitations of his/her respective license, provided that such treatment is Medically Necessary as defined by the Plan, and within recognized and accepted professional psychiatric and psychological standards and practices.

PSYCHIATRIC FACILITY

"Psychiatric Facility" means a licensed institution that provides Mental Illness treatment and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

PSYCHOLOGIST

"Psychologist" means a person currently licensed in the state in which services are rendered as a Psychologist and acting within the scope of his/her license.

QMCSO

"QMCSO" means Qualified Medical Child Support Order.

QUALIFIED BENEFICIARY

"Qualified Beneficiary" means an Employee, former Employee or Dependent of an Employee or former Employee who is eligible to continue coverage under the Plan.

"Qualified Beneficiary" will also include a child born to, adopted by or Placed for Adoption with an Employee or former Employee at any time during COBRA Continuation Coverage.

RECONSTRUCTIVE SURGERY

"Reconstructive Surgery" means a procedure to restore the anatomy and/or functions of the body, which are lost or impaired due to an Illness or Injury.

REGISTERED NURSE

"Registered Nurse" means an individual who has received specialized nursing training and is authorized to use the designation of "RN" and who is licensed by the state or regulatory agency in the state in which the individual performs such nursing services.

REHABILITATION FACILITY

"Rehabilitation Facility" means a legally operating institution or distinct part of an institution which has a transfer agreement with one or more Hospitals, and which is primarily engaged in providing comprehensive, multi-disciplinary physical restorative services, post-acute Hospital and rehabilitative Inpatient care and is duly licensed by the appropriate government agency to provide such services.

It does not include institutions which provide only minimal care, Custodial Care, ambulatory or part-time care services, or an institution which primarily provides treatment of Mental Illness or Substance Abuse/Chemical Dependency or tuberculosis, except if such facility is licensed, certified or approved as a Rehabilitation Facility for the treatment of Mental Illness or Substance Abuse/Chemical Dependency in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

RESIDENTIAL TREATMENT FACILITY

"Residential Treatment Facility" means an institution which:

1. Is licensed as a 24-hour residential facility for mental health and substance abuse treatment, although not licensed as a hospital;

2. Provides a multidisciplinary treatment plan in a controlled environment, with periodic supervision of a Physician or a Ph.D. Psychologist; and

3. Provides programs such as social, psychological and rehabilitative training, age appropriate for the special needs of the age group of patients, with focus on reintegration back into the community.

RETIREE

"Retiree" means a qualifying Retiree of The District School Board of Collier County, who meets the requirements of the Florida Statutes 121.091 for Normal, Early or Disability retirement are met.

ROOM AND BOARD

"Room and Board" refers to all charges which are made by a Hospital, Hospice, or Skilled Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians or intensive nursing care by whatever name called.

SKILLED NURSING FACILITY

"Skilled Nursing Facility" means an institution, or distinct part thereof, which meets all of the following conditions:

1. It is currently licensed as a long-term care facility or skilled nursing facility in the state in which the facility is located;

2. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled persons, custodial or educational care, or care of mental disorders; and

3. It is certified by Medicare.

This term also applies to Incurred Expenses in an institution known as a Convalescent Nursing Facility, Extended Care Facility, Convalescent Nursing Home, or any such other similar nomenclature.

SPECIALTY CARE PHYSICIAN

"Specialty Care Physician" includes any Physician who is practicing any branch of medicine or medical specialty who is not identified as a Primary Care Physician.

SPEECH THERAPY

"Speech Therapy" means a course of treatment, ordered by a Physician, to treat speech deficiencies or impediments.

SUBSTANCE ABUSE/CHEMICAL DEPENDENCY TREATMENT FACILITY

"Substance Abuse and/or Chemical Dependency Treatment Facility" means a licensed institution which provides a program for diagnosis, evaluation, and effective treatment of Substance Abuse and/or Chemical Dependency; provides detoxification services needed with its effective treatment program; provides infirmary-level medical services or arranges with a Hospital in the area for any other medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Nurse (RN); prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs which is supervised by a Physician; and meets licensing standards.

TELEMEDICINE

"Telemedicine" means the practice of medicine by electronic means, only for the purposes of diagnosis, providing medical advice and treatment to the Covered Person (patient), requiring direct contact between the Covered Person's (patient's) Licensed Health Care Provider and other Licensed Health Care Providers or entities in a different location. The Covered Person's (patient's) direct participation or physical presence is not a prerequisite for coverage if there is documentation that the consultation was conducted on behalf of the Covered Person for the purpose of diagnosing, providing medical advice or treatment to the Covered Person (patient). It is understood that the provider of medical information and advice through the telemedicine program is not the Covered Person's Primary Care Physician.

THE PATIENT PROTECTION & AFFORDABLE CARE ACT (PPACA)

"The Patient Protection & Affordable Care Act (PPACA) is a federal statute mandated by Federal Health Care Reform that was signed into law on March 23, 2010. The PPACA and the Health Care and Education Reconciliation Act of 2010 made up the health care reform of 2010.

THIRD PARTY ADMINISTRATOR

"Third Party Administrator" means the person or firm employed by the Plan to provide consulting services to the Plan in connection with the operation of the Plan and any other functions, including the processing and payment of claims. The Third Party Administrator is Allegiance Benefit Plan Management, Inc. The Third Party Administrator provides ministerial duties only, exercises no discretion over Plan assets and will not be considered a fiduciary as defined by any State or Federal law or regulation.

URGENT CARE FACILITY

"Urgent Care Facility" means a free-standing facility which is engaged primarily in diagnosing and treating Illness or Injury for unscheduled, ambulatory Covered Persons seeking immediate medical attention. A clinic or office located in or in conjunction with or in any way made a part of a Hospital will be excluded from the terms of this definition.

USERRA

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act, as amended.

USUAL, CUSTOMARY AND REASONABLE (UCR)"

"Usual, Customary and Reasonable (UCR)" means the maximum amount considered for payment by this Plan for any covered treatment, service, or supply, subject however, to all Plan annual maximum benefit limitations. The following will apply in the order below to determine the Usual, Customary, and Reasonable amount:

1. If there is a contracted rate with a provider network, or through any other discounting agreement, then the contracted rate for the claim applies.

2. If there is no contracted rate with a provider or through any other discounting agreement, then the UCR database utilized by the TPA and adopted by the Plan Administrator, using the 90th percentile of said database, applies.

3. If there is no contracted rate with a provider network, or through any other discounting agreement, then the billed charge for the claim applies, if it is less than the UCR data base amount.

4. If there is no contracted rate with a provider network, or through any other discounting agreement then the UCR database amount applies if the billed charge for the claim is more than the UCR database amount.

NOTICES

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT: Group health insurance issuers offering group health insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal 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 as applicable.

IDENTIFICATION OF FUNDING: Benefits under this Plan will be paid from Employee or Employer contributions up to the limits defined in the Plan Document and Summary Plan Description (SPD). Benefits in excess of the amount stated in the stop loss policy are reimbursable to the Employer by stop loss insurance, pursuant to the stop loss insurance contract or policy, subject, however, to the terms of this Plan and the stop loss insurance contract.

WOMEN'S HEALTH AND CANCER RIGHTS ACT: This Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all states of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call the Plan Administrator for more information.

HIPAA PRIVACY AND SECURITY STANDARDS

These standards are intended to comply with all requirements of the Privacy and Security Rules of the Administrative Simplification Rules of HIPAA as stated in 45 CFR Parts 160, 162 and 164, as amended from time to time.

DEFINITIONS

"Protected Health Information" (PHI) means information, including demographic information, that identifies an individual and is created or received by a health care provider, health plan, employer, or health care clearinghouse, and relates to the physical or mental health of an individual, health care that individual has received, or the payment for health care provided to that individual. PHI does not include employment records held by the Plan Sponsor in its role as an Employer.

"Summary Health Information" means information summarizing claims history, expenses, or types of claims by individuals enrolled in a group health plan and has had the following identifiers removed: names; addresses, except for the first three digits of the ZIP Code; dates related to the individual (ex: birth date); phone numbers; email addresses and related identifiers; social security numbers; medical record numbers; account or Plan Participant numbers; vehicle identifiers; and any photo or biometric identifier.

PRIVACY CERTIFICATION

The Plan Sponsor hereby certifies that the Plan Documents have been amended to comply with the privacy regulations by incorporation of the following provisions. The Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by the Plan Documents or as required by law. Such uses or disclosures may be for the purposes of Plan administration including, but not limited to, the following:

    A. Operational activities such as quality assurance and utilization management, credentialing, and certification or licensing activities; underwriting, premium rating or other activities related to creating, renewing or replacing health benefit contracts (including reinsurance or stop loss); compliance programs; business planning; responding to appeals, external reviews, arranging for medical reviews and auditing, and customer service activities. Plan administration can include management of carve-out plans, such as dental or vision coverage.

    B. Payment activities such as determining eligibility or coverage, coordination of benefits, determination of cost-sharing amounts, adjudicating or subrogating claims, claims management and collection activities, obtaining payment under a contract for reinsurance or stop-loss coverage, and related data-processing activities; reviewing health care services for Medical Necessity, coverage or appropriateness of care, or justification of charges; or utilization review activities.

    C. For purposes of this certification, Plan administration does not include disclosing Summary Health Information to help the Plan Sponsor obtain premium bids; or to modify, amend or terminate group health Plan coverage. Plan administration does not include disclosure of information to the Plan Sponsor as to whether the individual is a participant in; is an enrollee of or has disenrolled from the group health Plan.

2. Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

5. Make available PHI as required to allow the Covered Person a right of access to his or her PHI as required and permitted by the regulations;

6. Make available PHI for amendment and incorporate any amendments into PHI as required and permitted by the regulations;

7. Make available the PHI required to provide an accounting of disclosures as required by the regulations;

8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to any applicable regulatory authority for purposes of determining the Plan's compliance with the law's requirements;

9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information 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 information infeasible; and

10. Ensure that the adequate separation required between the Plan and the Plan Sponsor is established. To fulfill this requirement, the Plan Sponsor will restrict access to nonpublic personal information to the Plan Administrator(s) designated in this Plan Document or Employees designated by the Plan Administrator(s) who need to know that information to perform Plan administration and healthcare operations functions or assist eligible persons enrolling and disenrolling from the Plan. The Plan Sponsor will maintain physical, electronic, and procedural safeguards that comply with applicable federal and state regulations to guard such information and to provide the minimum PHI necessary for performance of healthcare operations duties. The Plan Administrator(s) and any Employee so designated will be required to maintain the confidentiality of nonpublic personal information and to follow policies the Plan Sponsor establishes to secure such information.

When information is disclosed to entities that perform services or functions on the Plan's behalf, such entities are required to adhere to procedures and practices that maintain the confidentiality of the Covered Person's nonpublic personal information, to use the information only for the limited purpose for which it was shared, and to abide by all applicable privacy laws.

SECURITY CERTIFICATION

The Plan Sponsor hereby certifies that its Plan Documents have been amended to comply with the security regulations by incorporation of the following provisions. The Plan Sponsor agrees to:

1. Implement and follow all administrative, physical, and technical safeguards of the HIPAA Security Rules, as required by 45 CFR §§164.308, 310 and 312.

2. Implement and install adequate electronic firewalls and other electronic and physical safeguards and security measures to ensure that electronic PHI is used and disclosed only as stated in the Privacy Certification section above.

3. Ensure that when any electronic PHI is disclosed to any entity that performs services or functions on the Plan's behalf, that any such entity shall be required to adhere to and follow all of the requirements for security of electronic PHI found in 45 CFR §§164.308, 310, 312, 314 and 316.

4. Report to the Plan Administrator or the Named Fiduciary of the Plan any attempted breach, or breach of security measures described in this certification, and any disclosure or attempted disclosure of electronic PHI of which the Plan Sponsor becomes aware.

THE DISTRICT SCHOOL BOARD OF COLLIER COUNTY
HEALTH BENEFITS PLAN
PLAN SUMMARY

The following information, together with the information contained in this booklet, form the Summary Plan Description.

1. PLAN

The name of the Plan is THE DISTRICT SCHOOL BOARD OF COLLIER COUNTY HEALTH BENEFITS PLAN, which Plan describes the benefits, terms, limitations and provisions for payment of benefits to or on behalf of eligible Participants.

2. PLAN BENEFITS

This Plan provides benefits for covered Expenses Incurred by eligible participants for:

Hospital, Surgical, Medical, Maternity, other eligible medically related, necessary expenses.

3. PLAN EFFECTIVE DATE

The effective date of the Plan is January 1, 2013, restated March 1, 2020.

4. PLAN SPONSOR

Name:	The District School Board of Collier County
Phone	(239) 377-0340
Address:	5775 Osceola Trail Naples, FL 34109-0919

5. PLAN ADMINISTRATOR

The Plan Administrator is the Plan Sponsor.

6. NAMED FIDUCIARY

Name:	The District School Board of Collier County
Phone	(239) 377-0340
Address:	5775 Osceola Trail Naples, FL 34109-0919

7. PLAN FISCAL YEAR

The Plan fiscal year ends June 30th.

8. PLAN TERMINATION

The right is reserved by the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time.

9. IDENTIFICATION NUMBER

Group Number:	2003022
Employer Identification Number:	59-6000557

10. THIRD PARTY ADMINISTRATOR

Name: Allegiance Benefit Plan Management, Inc.
Address: P.O. Box 3018
Missoula, MT 59806

11. ELIGIBILITY

Employees and Dependents of Employees of the Plan Sponsor may participate in the Plan based upon the eligibility requirements set forth by the Plan.

12. PLAN FUNDING

The Plan is funded by contributions from the Employer and Employees.

13. AGENT FOR SERVICE OF LEGAL PROCESS

The agent for service of legal process is the School Board Attorney, District General Counsel.

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Language Access Services: The information below is a requirement of Section 1557 of the Affordable Care Act effective August 18, 2016. It is required to assist those who may need assistance with the English language or translation assistance to a different language in which they are more fluent.

Allegiance Benefit Plan Management, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

تفاهكيم: (1062-999-855-1 . قمر) 1063-999-855 قمپر صنتلا .نجمالبا كلذ رفاوتنديةغوللا قسدعمالا تامدخنفإ ،ةغللا كرذا ثدتحتنكت اإذ :ةظحولم لاو مصلا

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-999-1062（TTY：1-855-999-1063）

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-999-1062 (TTY: 1-855-999-1063).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-999-1062 (TTY: 1-855-999-1063).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-999-1062 (ATS: 1-855-999-1063).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-999-1062 (TTY: 1-855-999-1063).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-999-1062 (TTY: 1-855-999-1063).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけま.1-855-999-1062（TTY:1-855-999-1063）まで、お電話にてご連絡ください.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-999-1062 (TTY: 1-855-999-1063) 번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-999-1062 (TTY: 1-855-999-1063).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-999-1062 (TTY: 1-855-999-1063).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-999-1062 (телетайп: 1-855-999-1063).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-999-1062 (TTY: 1-855-999-1063).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-999-1062 (TTY: 1-855-999-1063).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-999-1062 (TTY: 1-855-999-1063).